2012

Utah Annual Report of MEDICAID & CHIP

STATE FISCAL YEAR 2012
July 2011 - June 2012

UTAH DEPARTMENT OF HEALTH
MEDICAID
A Bridge to Wellness for Utah's Vulnerable

Utah Annual Report of Medicaid & CHIP

State Fiscal Year 2012

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State of Utah

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Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

December 31, 2012

Dear Fellow Utahn:

It is my privilege to present to you the 2012 Medicaid and CHIP Annual Report of the Utah Department of Health. This report includes activities from July 2011 to June 2012.

As the state's economy continues to recover, health coverage through Medicaid is still vital for Utah's low income families and individuals who are elderly or who have disabling conditions. In State Fiscal Year (SFY) 2012, Utah's Medicaid program provided health care to approximately 398,000 Utahns.

While Medicaid's total expenditures continue to increase with the growing number of enrollees, the per member cost decreased an average of three percent per year over the last four years. This notable feat in containing per member costs is the result of Medicaid's continual effort to improve current systems and processes, as wells as develop innovative approaches in providing sustainable, accessible and quality health care for its enrollees, even in the face of budget constraints.

Although this report is a statistical overview of the program, it is also just as important to acknowledge the value of Medicaid for thousands of Utahns who access the services that protect their health and sometimes save their lives. Throughout this report, you will find personal stories of Utahns that need Medicaid. While it is concerning that the economy and other circumstances have increased the number of individuals eligible for Medicaid, it is good to know health care services were available to them in times of need.

The Department looks forward to the continued cooperation with the Governor's Office, the Legislature, the Medicaid provider community and the citizens. Together we can work to ensure Utah's Medicaid program manages its limited resources as efficiently and effectively as possible in order to provide health care services to Utah's most vulnerable populations.

Sincerely,

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

UTAH DEPARTMENT OF HEALTH

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Division of Medicaid and Health Financing

The Utah Department of Health (DOH), Division of Medicaid and Health Financing (DMHF), through state and federal resources, provides funding for medical services to needy individuals and families throughout the State. The Division of Medicaid and Health Financing administers two programs, Medicaid and the Children's Health Insurance Program (CHIP).

The administration of Medicaid and CHIP is accomplished through the office of the Division Director and six bureaus. The Division Director administers and coordinates the program responsibilities delegated to develop, maintain and administer the Medicaid program in compliance with Title XIX and the CHIP program in compliance with Title XXI of the Social Security Act, the laws of the state of Utah, and the appropriate budget. Contract development and monitoring, staff training and development, and inventory control are coordinated from the Director's office. Each bureau has the following responsibilities:

Bureau of Financial Services - The objectives and responsibilities of this bureau include monitoring, coordinating and facilitating the Division's efforts to operate economical and cost-effective medical assistance programs. The bureau is responsible for coordinating and monitoring federally mandated quality control systems, including monitoring of the Medicaid, CHIP, Utah's Premium Partnership for Health Insurance (UPP), and Primary Care Network (PCN) service programs, providers, and all third-party liability (TPL) activity. The bureau also performs budget forecasting and preparation, appropriation requests, legislative presentations, monitoring of medical assistance programs and administration of expenditures and federal reporting.

Bureau of Managed Health Care - The main objective of this bureau is to provide Medicaid and CHIP clients with a choice of health care delivery programs in order to enable them to use medical assistance program benefits properly. Secondly, this bureau monitors the performance of the capitated programs under both Medicaid and CHIP. Lastly, the bureau operates the early periodic screening, diagnosis, and treatment (EPSDT) program that provides well-child health care.

Bureau of Authorization and Community-Based Services - The general responsibilities of this bureau include policy formulation, interpretation and implementation planning of quality, cost-effective long-term care services that meet the needs and preferences of Utah's low-income citizens. In addition, the bureau is responsible for prior authorizations of Medicaid services.

Bureau of Medicaid Operations – This bureau's main objectives are to oversee the accurate and expeditious processing of claims submitted for covered services on behalf of eligible beneficiaries and the training of providers regarding allowable Medicaid expenditures and billing practices. The general responsibilities include processing, and adjudication of medical claims; publishing all provider manuals; and being the single point of telephone contact for information about client eligibility, claims processing, and general questions about the Medicaid program.

Bureau of Coverage and Reimbursement Policy - The general responsibilities of this bureau include policy formulation, interpretation, and implementation planning. This responsibility encompasses scope of service and reimbursement policy for Utah's Medicaid program. The bureau also oversees the pharmacy program, drug utilization review, and the Preferred Drug List, as well as maintains the State Plan.

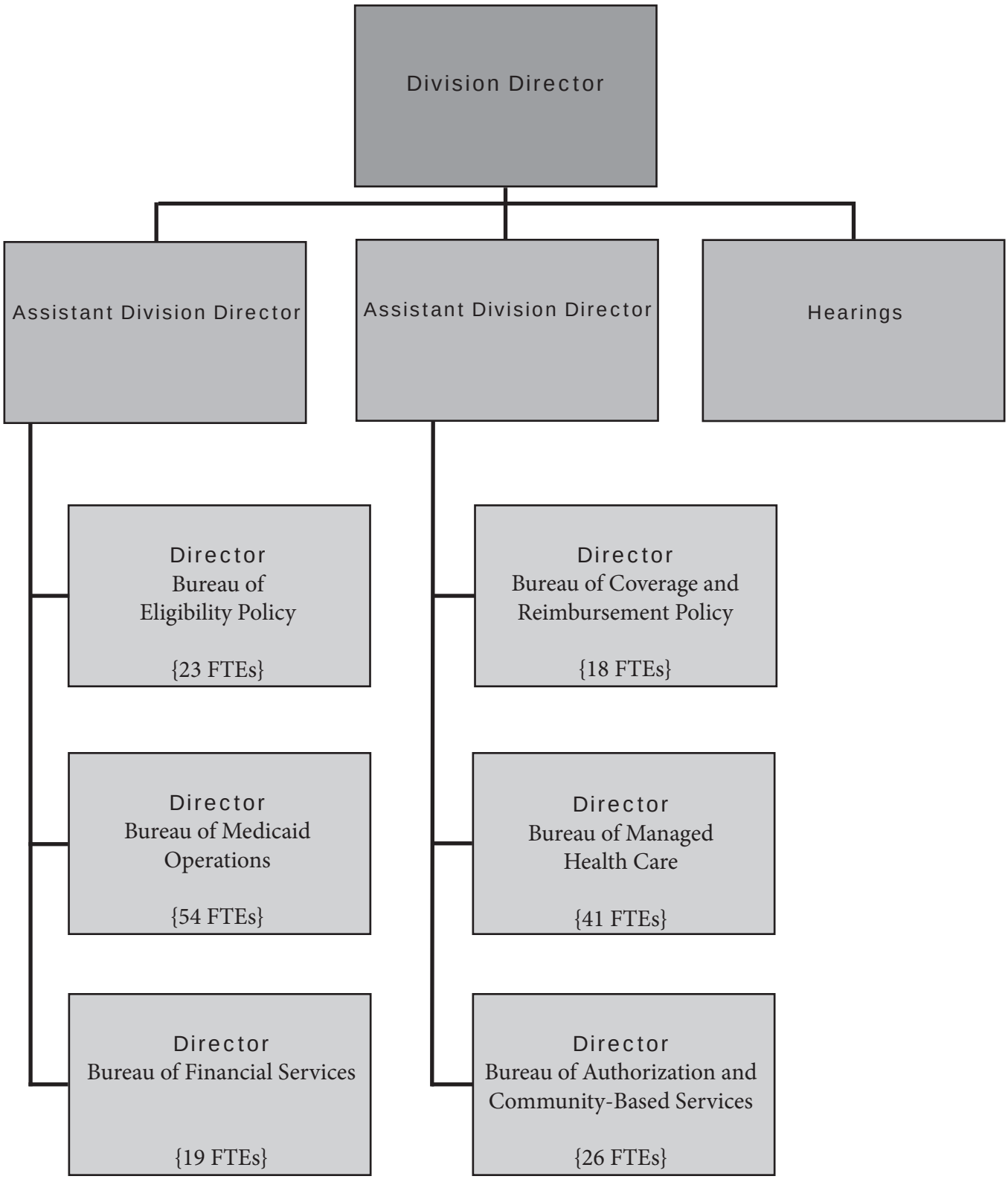
Bureau of Eligibility Policy - The primary responsibility of this bureau is to oversee eligibility determinations

for the Medicaid and CHIP programs. This includes: interpreting federal or state regulations and writing medical eligibility policy; providing timely disability decisions based on Social Security Disability criteria; monitoring the accuracy and timeliness of the Medicaid program by reviewing eligibility determinations under guidance from the Centers for Medicare and Medicaid Services (CMS); purchasing private health insurance plans for Medicaid recipients who are at high risk, which saves Medicaid program dollars; and monitoring for program accuracy.

Mission Statement

The mission of the Division of Medicaid and Health Financing
is to provide access to quality, cost effective health care for eligible Utahns.

Division of Medicaid and Health Financing Organizational Chart



Division Highlights SFY 2012

- The Division answered more than 1 million calls from providers and/or clients by Medicaid customer service representatives, including prior authorizations.
- The Division processed more than 8.6 million claims.
- The Division received 679,143 calls through Access Now, an automated eligibility line.
- The Division enrolled 3,757 new providers and re-credentialed 5,435 providers.
- The Division processed approximately 37,000 prior authorization requests.
- The Division's Technical Writing Unit submitted 19 State Plan Amendments and 52 State Administrative Rules.
- The Division added 18 new drug classes to the Preferred Drug List (PDL), now totalling 70 classes on the PDL. These drug class additions, combined with savings from existing PDL classes are expected to generate annualized PDL savings of approximately $34.1 million in state and federal funds.
- The Division implemented a new pharmaceutical point of sale system. The system provides improved prior authorization functions; a new Medicaid Drug Rebate invoicing/accounting system; and a provider portal for prescribing information look-up and prior authorization entry.
- The Division contracted with a new vendor for state maximum allowable cost (SMAC) and pharmaceutical quarterly pricing surveys. The Division also engaged in quarterly SMAC pricing updates which helped reduce the prices paid for certain drugs.
- The Division implemented rate changes for procedure codes in the following programs:
  - Traditional Medicaid – 13,288
  - Non–Traditional Medicaid – 13,276
  - Primary Care Network (PCN) – 13,007
- The Division worked with contracted actuaries to set certified rates for the eleven contracted mental health centers, as well as converted fee-for-service substance abuse services into the capitated model.
- The Division worked with the contracted actuaries to set certified rates for the capitated, risk-based managed care organization, in addition to developing a methodology for the Accountable Care Organization (ACO) rate setting.
- The Division made the following supplemental payments:
  - Nursing Facility Quality Improvement Incentive I program (62 applications processed and $1,000,000 paid).
  - Nursing Facility Quality Improvement Incentive II program (278 applications processed and $3,764,294 paid).
  - ICF/ID Quality Improvement Incentive I program (14 applications processed and $200,000 paid).
  - Disproportionate Share Hospital (DSH) (65 payments, totalling $34,060,749).
  - Graduate Medical Education (GME) (33 payments, totalling $6,336,524).
  - Hospital Access Payments (138 payments, totalling $146,621,774).
  - State Teaching Hospital Supplemental Payment (8 payments, totalling $54,613,331).
  - Outpatient Hospital Supplemental Payment (30 payments, totalling $8,369,397).
  - University of Utah Medical Group Supplemental Payment (4 payments, totalling $8,600,443).
- The Division began planning the implementation of the Medicaid Autism Waiver Pilot Program, to assist children ages 2 through 5 who have been diagnosed with an autism spectrum disorder (ASD).
- The Division created a new Coverage and Reimbursement Code Lookup web tool to facilitate providers identifying pertinent coverage and pricing information. The tool is available at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php

- PCN, a limited-benefit Medicaid program, was open for enrollment in March, successfully enrolling an additional 5,783 uninsured adults.
- Through the Robert Wood Johnson Foundation grant, Maximizing Enrollment for Kids, the Division has worked to streamline systems, policies and procedures to reduce barriers to enrollment and retention of eligible children in Medicaid and CHIP. In conjunction with this grant, the Division identified and aligned five of eight policy changes in Medicaid and CHIP to meet the federal CHIPRA Performance Bonus. The state will receive a $10 million bonus in 2013.
- The Division has been studying, researching and planning the implementation of the Patient Protection and Affordable Care Act (PPACA).
- The Division submitted an 1115 Waiver Request to the federal government to transform the way Utah operates its Medicaid program in order to attempt to slow the growth of its costs. Although the Waiver Request was not approved in full, the following components are being implemented as part of Utah's Accountable Care Organization (ACO) model:
  - Restructure provider payments using risk adjusted capitated payments for all of its ACO contracts and pay providers for episodes of care rather than for billable events in an effort to maintain or improve the quality of care and recipient health status.
  - Integrate non-behavioral pharmacy benefits into the ACO scope of service to better align the incentive of prescribers with the goals of the State.
  - Reward recipients for personal efforts to maintain or improve their health.
- The Division implemented a chronic disease management program using electronic system criteria for the identification and surveillance of Medicaid recipients with a diagnosis of Diabetes, Type I or II, who continue to seek primary care from the Emergency Department (ED) and/or only seek care in the ED once their Diabetes symptoms become critical in nature. Each new alert of an ED visit for diabetes related treatment prompts direct contact to the client offering information and resources with the goal of decreasing ED visits and overall medical costs.
- The Division participated in the Electronic Health Record (EHR) Incentive Payment Program, as described in the American Recovery and Reinvestment Act (ARRA) Section 4201, by providing incentive payments to eligible professionals and hospitals for the adaptation of certified Electronic Health Records (EHR) and the exchange of quality health care records through Health Information Exchange (HIE). Since October 2011, 310 providers and hospitals have successfully attested with Utah Medicaid indicating they have successfully adopted, implemented or upgrade to certified EHR technology. As of September 30, 2012, incentive payments totalling $13,400,395 have been awarded.
- The Division embarked on the planning and implementation of limited Emergency Dental Services for adult Medicaid clients, in order to provide better access and an alternative to costly emergency room visits. Covered services include x-rays, extractions, and incision and drainage of abscesses.

Medicaid Finance

The Utah Department of Health (DOH), Division of Medicaid and Health Financing (DMHF) provides funding for medical services to needy individuals and families throughout the State through state and federal resources. DMHF administers the Medicaid program through Title XIX of the Social Security Act.

Means of Finance

Medicaid was established by Title XIX of the Social Security Act in 1965 and may be referred to as the "Title XIX" assistance program. As an entitlement program, the number of eligible people is limited only by the established categories of eligibility and not by the federal and state government. Utah began its Medicaid program for acute and long-term care in 1966. DOH is designated as the single State agency responsible for making state applications to the federal government for all Medicaid funding and Medicaid-related programs. Medicaid is a partnership program between the federal and state government that makes coverage available for basic health and long-term care services and is based on income level and/or resources.

The Medicaid program is under the direction of the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). CMS sets requirements that include funding, qualification guidelines and quality and extent of medical services. CMS also has the responsibility of monitoring the program.

Medicaid is funded by a share of both federal and state funds. This share is based on the Federal Medical Assistance Percentages (FMAP), which are updated every Federal Fiscal Year (FFY). The FFY runs from October 1 to September 30. The National FMAP will range from 50 percent to 73.4 percent of program cost. It is based on each state's latest three year average per capita income. Table 1 is a ten year historical list of Utah FMAP running from 2003 to 2013, modified to match the State Fiscal Year (SFY).

Federal Medicaid Assistance Percentages (FMAP)
SFY 2003 – SFY 2013

SFY	Federal Percentage	State Percentage
2003	70.93%	29.07%
2004	71.60%	28.40%
2005	72.04%	27.96%
2006	71.11%	28.89%
2007	70.30%	29.70%
2008	71.26%	28.74%
2009	70.94%	29.06%
2010	71.44%	28.56%
2011	71.27%	28.73%
2012	71.03%	28.97%
2013	69.96%	30.04%

Table 1

Utah Medicaid generally receives approximately 70 percent of its funding from the Federal match and 30 percent from the State General fund. During fiscal years 2009 – 2011, the federal government provided a temporary increase to the FMAP as specified in the American Recovery and Reinvestment Act (ARRA). Those increases are not specified in table 1.

Medicaid Revenues and Expenditures

Expenditures for Medicaid correspond to the enrollment numbers which are affected by economic, demographic and age-mix factors. Understanding the relationship of these factors is a key to projecting future costs for the Medicaid program. Medicaid program expenditures have seen an overall increase from $1.87 billion in 2011 to $1.97 billion in 2012, an increase of 5.4 percent (see Figure 1). In SFY 2012, the average expenditure per member per month (PMPM) was $597 compared to $596 in SFY 2011.

Figure 1 illustrates the total Medicaid program expenditure trend for the past five years, excluding administrative costs and Office of the Attorney General (AG) expenditures.

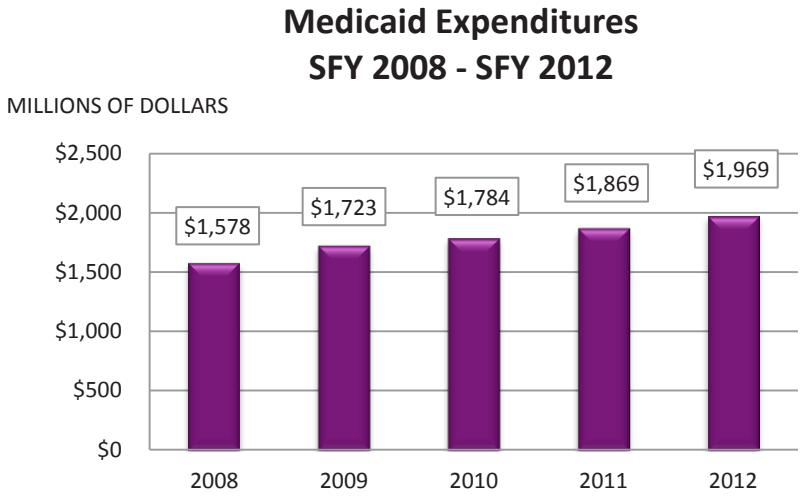


Figure 1

Expenditures incurred by clients through the Medicaid program are paid directly to licensed providers of medical care. Under federal law, participating providers must accept the reimbursement level as payment in full. Several methods are used to determine provider reimbursement, including limited fees for service, negotiated capitation rates, and client acuity-based rates for nursing home services.

As in years past, most of the DMHF expenditures are pass–through charges (98 percent). The other major charge is personnel services which accounts for almost 1 percent of the total expenditures (see Figure 2).

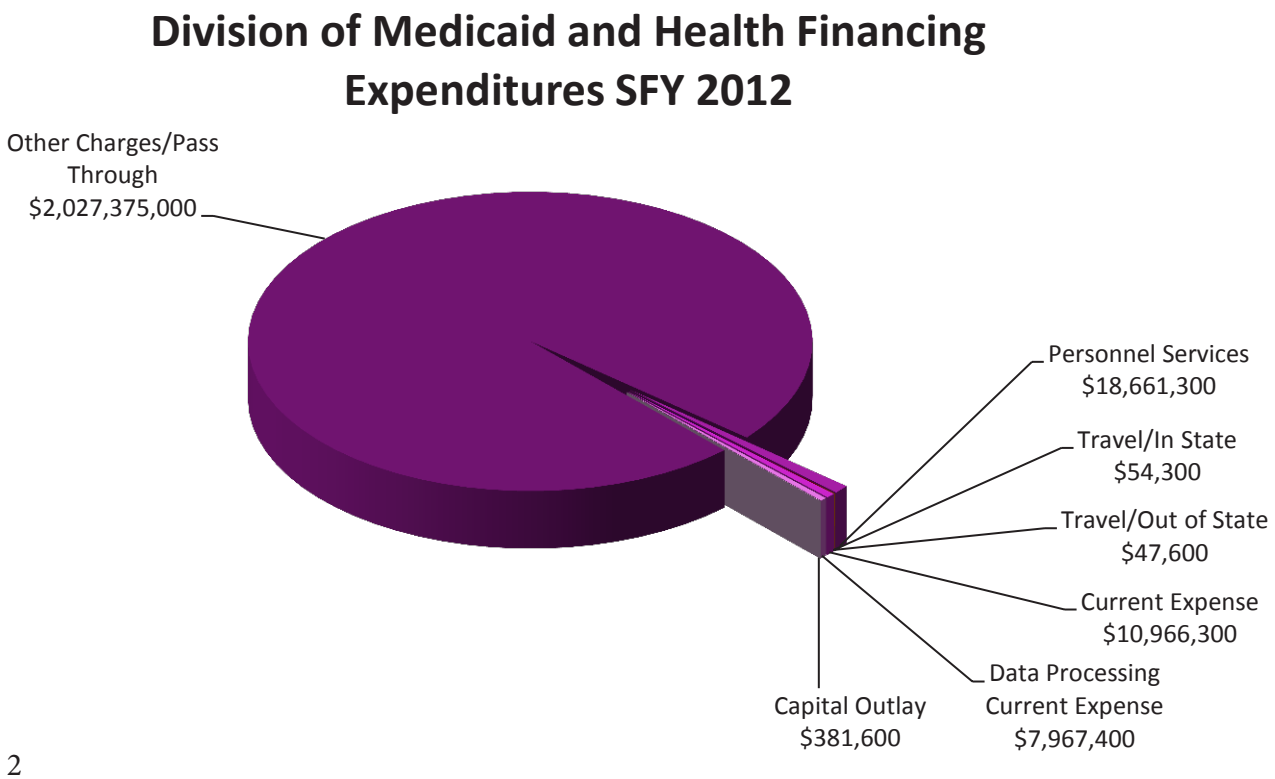

Division of Medicaid and Health Financing
Expenditures SFY 2012
Other Charges/Pass Through $2,027,375,000
Personnel Services $18,661,300
Travel/In State $54,300
Travel/Out of State $47,600
Current Expense $10,966,300
Data Processing Current Expense $7,967,400
Capital Outlay $381,600

Figure 2

The DMHF's revenues include different fund sources that are used to match Medicaid or used for special programs in the Division. The revenue consists of General Fund, Dedicated Credits, Restricted Revenues, Transfers and the associated Federal Funds. Transfers are funds from other State Departments, referred as "seeded funds", which are federally matched using FMAP. Figure 3 shows a breakout of the types of revenue and the amount of each source of revenue in 2012.

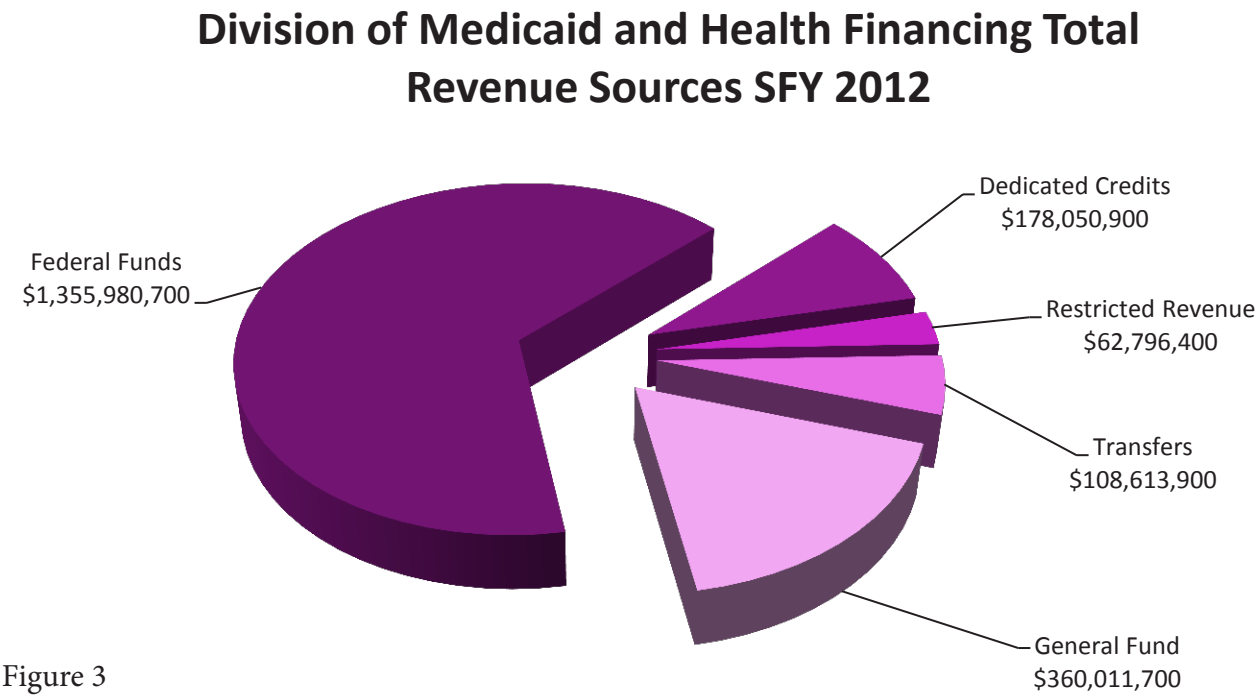


Figure 3

Offsets to Medicaid Expenditures

In SFY 2012 a total of $2.07 billion (State and Federal resources) was expended for Medicaid in the state of Utah. Every effort is made by the various State agencies that receive Medicaid funding to offset these expenditures and thereby decrease the total resources allocated to Medicaid. In SFY 2012 a total of $356,813,500 was used to offset Medicaid expenditures. These offsets are described and detailed in Table 2.

Co-payments - Medicaid clients are required to pay a portion of the cost for some of the services they receive. For example, clients pay $3 per prescription up to a maximum of $15 per month. Total co-payments collected in SFY 2012 amounted to $6,519,500.

Third Party Liability - Services a Medicaid client receives can sometimes be billed to a third party provider such as Medicare. The Office of Recovery Services (ORS) also collects monies from these third parties. In SFY 2012 $244,936,700 was collected or charged from/to third parties.

Pharmacy Rebates - Pharmacy retailers offer volume discount rebates to DOH. In SFY 2012, DOH received $90,003,000 in pharmacy rebates.

Spenddown Income - If a potential Medicaid client's exceeds the eligibility threshold, they have the option to spenddown (or pay part of) their income in order to become eligible for Medicaid. In SFY 2012, Medicaid clients spent down $6,922,200.

Other Collections – The Attorney General's Office (AG) and Office of Medicaid Inspector General (OIG) are actively involved in recovering overpayments. In SFY 2012, the AG and OIG collected $8,955,700.

Primary Care Network (PCN) Premiums - Adults must pay an annual premium, up to $50, to be eligible for this program. In SFY 2012, a total of $302,100 was collected.

Medicaid Client Story:

Two brothers, Benny and Gabriel, were born to a mother with a history of chronic substance abuse. Upon birth, each child was immediately placed into foster care. Both boys had extensive medical needs, but were adopted by their foster family. "Although now they are two basically healthy little boys, they were far from that when we first started fostering them…If it wasn't for Medicaid coverage, I don't know how we could afford to have these two little guys in our family," said their adopted mother, Wendy.

Expenditure Offsets - FY 2012 - Actual

Category Of Service	Co-Payment	Third Party	Rebates	Spenddown and Other Collections	Premiums	Total
Inpatient Hospital Services, General	$928,800	$87,190,600	$0	$0	$0	$88,119,400
Inpatient Hospital Services, Mental	$0	$0	$0	$0	$0	$0
Outpatient Hospital Services, General	$300,600	$30,816,000	$0	$0	$0	$31,116,600
Nursing Facility II (NF II)	$0	$3,800	$0	$0	$0	$3,800
Nursing Facility III (NF III)	$0	$244,700	$0	$0	$0	$244,700
Nursing Facility I (NF I)	$0	$24,015,300	$0	$0	$0	$24,015,300
Home Health Services	$0	$7,088,100	$0	$0	$0	$7,088,100
Personal Care	$0	$6,900	$0	$0	$0	$6,900
Substance Abuse Treatment Services	$0	$67,600	$0	$0	$0	$67,600
Independent Lab and/or X-Ray Services	$2,400	$631,400	$0	$0	$0	$633,800
Ambulatory Surgical Services	$3,100	$1,125,800	$0	$0	$0	$1,128,900
Contracted Mental Health Services	$0	$21,300	$0	$0	$0	$21,300
Mental Health Services	$0	$1,314,900	$0	$0	$0	$1,314,900
Rural Health Clinic Services	$0	$244,100	$0	$0	$0	$244,100
ESRD Kidney Dialysis Services	$1,000	$6,493,200	$0	$0	$0	$6,494,200
Pharmacy	$4,489,000	$6,949,800	$90,003,000	$0	$0	$101,441,800
Specialized Wheel Chairs	$0	($3,900)	$0	$0	$0	($3,900)
Medical Supply Services	$2,300	$6,637,000	$0	$0	$0	$6,639,300
Occupational Therapy	$1,000	$106,700	$0	$0	$0	$107,700
Medical Transportation	$0	$4,906,800	$0	$0	$0	$4,906,800
Specialized Nursing Services	$0	$621,900	$0	$0	$0	$621,900
Well Child Care (EPSDT) Services	$0	$407,200	$0	$0	$0	$407,200
Physician Services	$490,500	$34,369,800	$0	$0	$0	$34,860,300
Federally Qualified Health Centers	$8,300	$315,400	$0	$0	$0	$323,700
Dental Services	$136,200	$2,548,200	$0	$0	$0	$2,684,400
Pediatric/Family Nurse Practice	$24,100	$290,000	$0	$0	$0	$314,100
Psychologist Services	$0	$372,900	$0	$0	$0	$372,900
Physical Therapy Services	$16,500	$890,000	$0	$0	$0	$906,500
Speech and Hearing Services	$0	$94,000	$0	$0	$0	$94,000
Podiatry Services	$8,400	$841,300	$0	$0	$0	$849,700
Vision Care Services	$10,400	$279,800	$0	$0	$0	$290,200
Optical Supply Services	$0	$62,100	$0	$0	$0	$62,100
Osteopathic Services	$96,700	$2,269,200	$0	$0	$0	$2,365,900
QMB-Only Services	$0	$2,911,200	$0	$0	$0	$2,911,200
Aging Waiver Service	$0	$800	$0	$0	$0	$800
Chiropractic Services	$200	$17,800	$0	$0	$0	$18,000
Targeted Case Management Services	$0	($700)	$0	$0	$0	($700)
Group Pre/Postnatal Education	$0	$200	$0	$0	$0	$200
Nutritional Assessment Counseling	$0	$900	$0	$0	$0	$900
New Choices Waiver Services	$0	$0	$0	$0	$0	$0
Primary Care Network Premiums	$0	$0	$0	$0	$302,100	$302,100
Attorney General/OIG	$0	$825,652	$0	$8,130,008	$0	$8,955,660
ORS Collections	$0	$19,958,900	$0	$6,922,200	$0	$26,881,100
TOTAL	**$6,519,500**	**$244,936,652**	**$90,003,000**	**$15,052,208**	**$302,100**	**$356,813,460**

Table 2

Medicaid Client Story:

In 2009, during the difficult economic downturn, Seth was laid off from his job. Shortly after, his wife, Rachel, found out she was pregnant. They were incredibly thankful to find out that their entire family was eligible for Medicaid. Because of early detection, their new baby was diagnosed with a rare genetic disorder but has been able to receive vital medical care through Medicaid. "Knowing [my kids have] Medicaid gives me peace of mind," said Rachel. Life has started to turn around for this family. Seth recently finished training to become a medical assistant and has a secure job that will soon offer health insurance for the entire family.

Medicaid Enrollment

The enrollment process and eligibility determinations for Medicaid are made primarily by the Department of Workforce Services (DWS), with a limited number done by the Department of Human Services (DHS). Eligibility requirements for Medicaid are based on Title XIX of the Social Security Act. There are over 30 types of Medicaid classifications, each with varying eligibility requirements. Eligibility always considers household income. Most programs limit the assets that an individual or a family may have in order to qualify.

The total number of distinct enrollees for the Medicaid program in SFY 2012 was 397,813 and compared with 373,954 in SFY 2011 - an increase of 6.3 percent. Most Medicaid costs are federally matched. Eligible clients are divided by category of assistance. Figure 4 illustrates the major categories and their percentage of the total. The majority of eligible clients is made up of children. In 2012, approximately 57 percent of Medicaid recipients were children.

- Children (individuals under age 19)
- Parents (adults in families with dependent children)
- Pregnant women
- Individuals with a disability (individuals who have been determined disabled by Social Security)
- Aged individuals (age 65 or older)
- Blind individuals (individuals of any age who meet Social Security's criteria for statutory blindness)
- Women with breast or cervical cancer
- Individuals who participate in a Medicare Cost-Sharing Program
- Adults on the Primary Care Network (PCN) program (low-income individuals, ages 19-64, who do not meet criteria for any of the above listed groups)

Figure 4 illustrates SFY 2012 eligible clients by category of assistance.

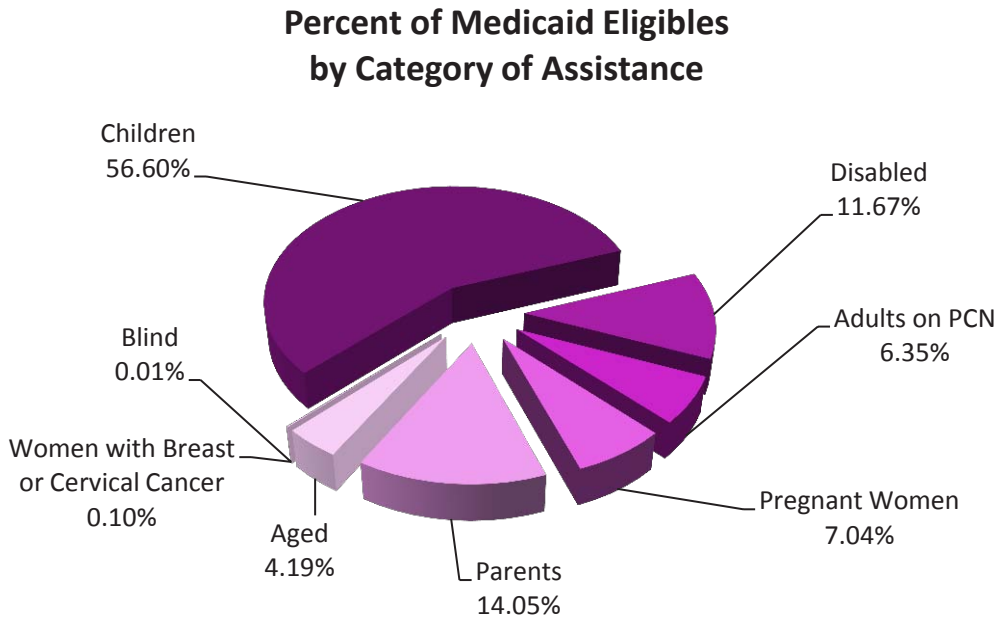


Figure 4

Qualification for Medicaid

Medicaid serves as the nation's primary source of health insurance coverage for low-income populations. Medicaid provides funding for individuals and families who meet the eligibility criteria established by the state of Utah and approved by CMS. Providers of health care services to Medicaid enrollees are reimbursed by Medicaid.

In order to receive federal funding participation, the state of Utah agrees to cover certain groups of individuals (mandatory groups) and offer a minimum set of services (mandatory services). Through waivers, the state of Utah is also able to receive federal matching funds to cover additional services (optional services), as well as additional qualifying groups of individuals (optional groups).

Each state sets an income limit within federal guidelines for Medicaid eligibility groups and determines what income counts toward that limit. Family size plays a part in the financial qualification for Medicaid. Below Table 3 shows the 2012 HHS Federal Poverty Guidelines (FPG). These federal poverty guidelines show what is considered to be the poverty level standard of living. For example, a four person family is considered living at 100 percent of FPG if the household income is $23,050 annually ($1,921 per month) and at 200 percent of FPG if the household income is $46,100 annually ($3,842 per month).

Table 3 shows the 2012 HHS Poverty Guidelines.

2012 HHS Poverty Guidelines			
Persons in Family	**100%**	**150%**	**200%**
1	$11,170	$16,755	$22,340
2	$15,130	$22,695	$30,260
3	$19,190	$28,635	$38,180
4	$23,050	$34,575	$46,100
5	$27,010	$40,515	$54,020
6	$30,970	$46,455	$61,940
7	$34,930	$52,395	$69,860
8	$38,890	$58,335	$77,780
For each additional person, add	$3,960	$5,940	$7,920

Source: https://www.federalregister.gov/articles/2012/01/26/2012-1603/annual-update-of-the-hhs-poverty-guidelines#t-1
As of September 10, 2012

Table 3

Figure 5 summarizes income requirements for many of the Medicaid programs. As shown in the eligibility chart, maximum income levels exist for different groupings. While most eligibility categories allow access to the full array of Medicaid services, the individual's economic and medical circumstances may assign an enrollee to a more limited set of benefits. For example, a pregnant woman may be eligible for medical assistance if her annual income is less than or equal to 133 percent of the FPG. A child eligible for CHIP will have a different level of cost sharing if the family income is less than 100 percent FPG than a CHIP eligible child from a family with income between 150 percent and 200 percent FPG.

Income Limits for Medical Assistance & Medicaid Cost-Sharing Programs

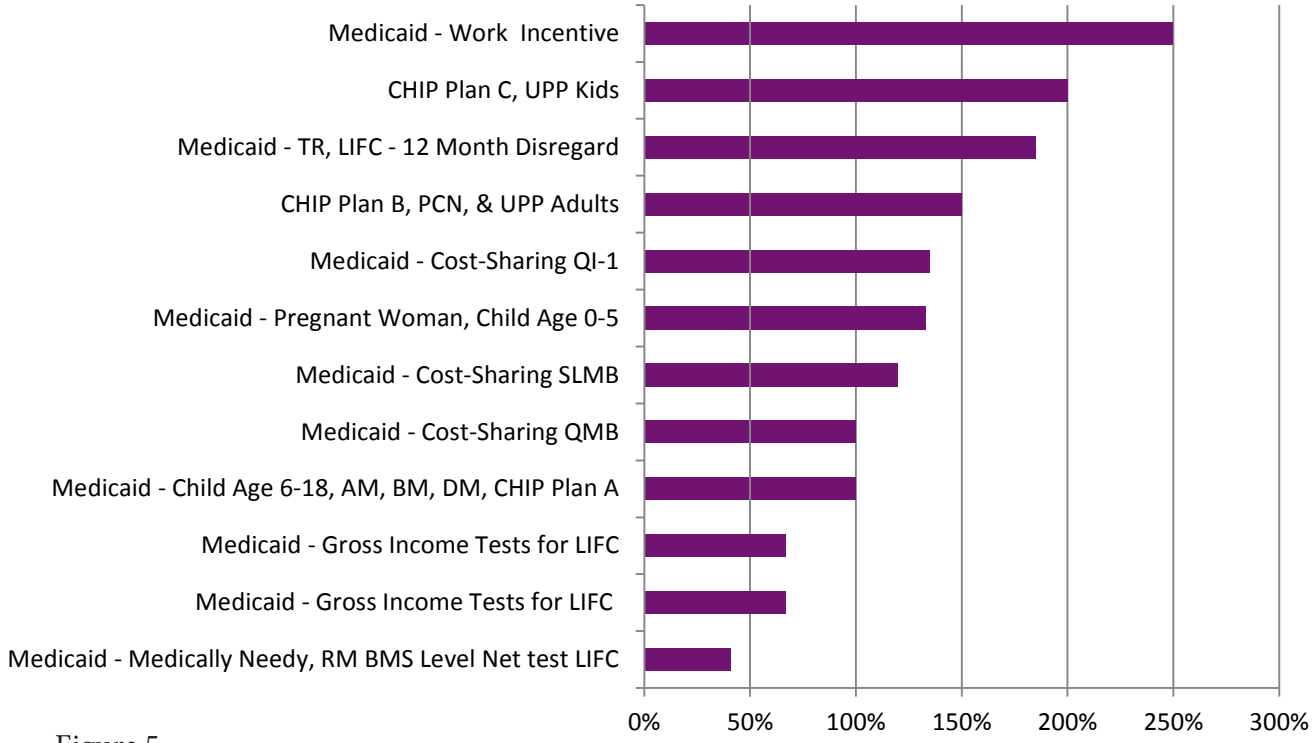


Figure 5

Medicaid enrollment numbers and corresponding expenditures are impacted by economic, demographic and age-mix factors. As we study these factors we are better able to predict future enrollment and financial characteristics of the Medicaid population.

The percentage of the Utah population living under the FPGs influences the level of state reliance on the Medicaid program services. In 2011, the percentage of individual living at or below 100 percent of the FPG was 10 percent in Utah. This is compared to the U.S. national average of 15.1 percent. The percentage of the Utah population living at or below 200 percent of the FPG is 28.5 percent compared to 33.9 percent nationally.

Poverty Level	U.S.	Utah
Below 100% of Poverty	15.1%	10.0%
101% - 125% of Poverty	19.8%	13.8%
126% - 135% of Poverty	21.6%	15.9%
136% - 150% of Poverty	24.6%	18.6%
150% - 185% of Poverty	31.3%	26.0%
186% - 200% of Poverty	33.9%	28.5%

Source: United States' Census Bureau found at http://www.census.gov/hhes/www/cpstables/032012/pov/POV46_001.htm

Table 4

Unemployment rates also have a major effect in state reliance on Medicaid programs. An increase in the unemployment rate typically correlates with an increase in the number of individuals eligible for Medicaid. In 2008, the average number of members enrolled each month in Medicaid was 198,000 and the average number enrolled each month in Medicaid in 2011 was 261,000. This enrollment number has increased each year.

When we look at the unemployment rates in Utah during 2008, 2009, 2010 and 2011, we see an increase in the rate for most of these years (3.7, 6.6, 8.0, and 6.7 respectively). The unemployment rates across the U.S. over this same period were 5.8, 9.3, 9.6, and 9.0, respectively.

Medicaid Benefits

Medicaid benefits vary, from person to person, depending on differences in:

- Age
- Pregnancy
- Category of Assistance
- Other

Differences in benefits include:

- PCN covers only primary care services
- Individuals who are not pregnant or are not a child may have co-payment or cost-sharing requirements
- Other

As shown in Figure 6, although children make up 57 percent of the Medicaid recipients, they only account for 27 percent of the total Medicaid expenditures. Individuals with disabilities account for 44 percent of the total Medicaid expenditures (see Figure 6).

Income and asset tests are primary factors in determining eligibility. The Medicaid program must provide medical services to "Categorically Needy" individuals. Many categorically needy optional groups and medically needy individuals are covered in Utah as a state option. "Medically Needy" individuals have enough income to meet basic living costs, but are unable to afford vital medical care. In previous years, all supplemental payments were coded to the Aged category of assistance. Since supplemental payments are paid on behalf of all populations, supplemental payments were carved out of the analysis and then distributed proportionally. This accounts for the proportional reduction of Aged versus this figure in previous versions of the annual report.

Figure 6 illustrates total SFY 2012 Medicaid expenditures by category of assistance.

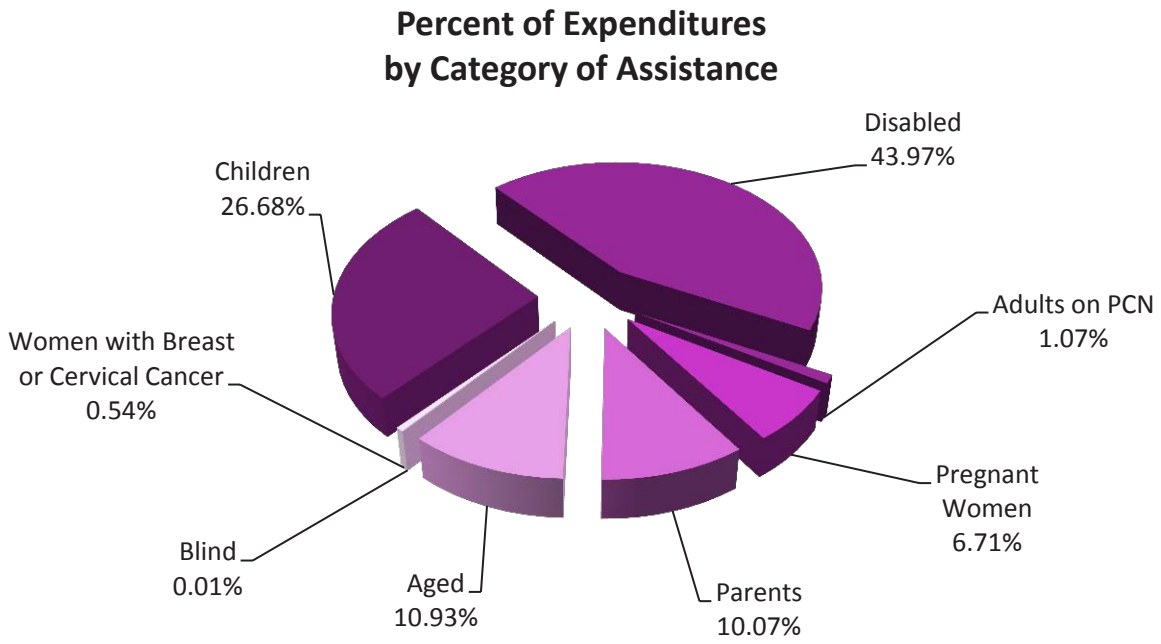


Figure 6

Enrollment Statistics

A Medicaid eligible is a person who may fit the established eligibility criteria of the program, whether or not the person applied for Medicaid.

A Medicaid enrollee is a person fitting the established eligibility criteria of the program, who has applied and been approved by Medicaid to receive services, regardless of whether the enrollee received any service or any claim has been filed on his or her behalf.

An accurate method of estimating Medicaid enrollment is to calculate the average number of individuals enrolled per month, or the average member months. Figure 7 shows the number of member months in thousands over the past five state fiscal years. Average member months increased from 261,067 in SFY 2011 to 274,812 in SFY 2012. This is an increase of 5.3 percent.

Figure 7 illustrates the number of member months over the past five years.

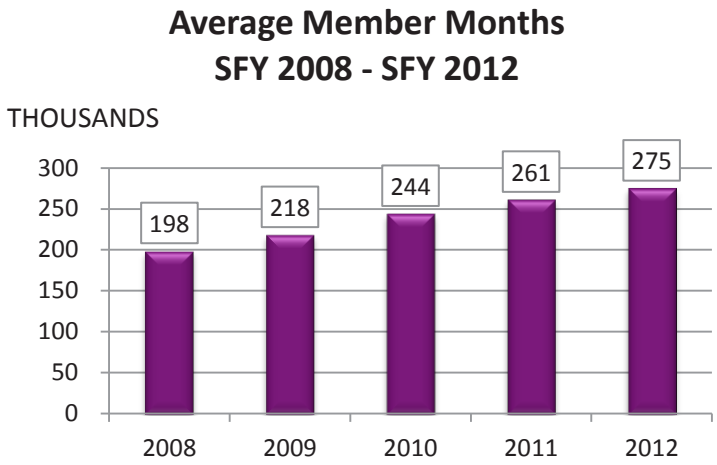


Figure 7

A Medicaid recipient is an enrollee with at least one processed claim during the time period involved. In this case during SFY 2012, whether or not the recipient was enrolled on the date the claim was paid, they were enrolled at the time the service for the claim was provided. For example, there may be a processed claim during this particular period for services that were provided in a prior period for an individual and his or her eligibility ended before this state fiscal year.

As of June 2012, there were 274,996 Medicaid enrollees. Of these enrollees, the gender, race and age groups are as follows:

Medicaid Enrollees Age 18 or Less (as of June 2012)			
Race	**Female**	**Male**	**Total**
White	58,714	62,525	121,239
Other	15,724	16,524	32,248
Native American	2,593	2,744	5,337
Black	2,469	2,667	5,136
Asian	1,256	1,364	2,620
Pacific Islander	1,240	1,320	2,560
Total	**81,996**	**87,144**	**169,140**

Table 5

Medicaid Enrollees Age 19 through Age 64 (as of June 2012)			
Race	**Female**	**Male**	**Total**
White	51,138	25,911	77,049
Other	5,213	2,594	7,807
Native American	1,921	931	2,852
Black	1,489	878	2,367
Asian	1,270	769	2,039
Pacific Islander	478	255	733
Total	**61,509**	**31,338**	**92,847**

Table 6

Medicaid Enrollees Age 65 or Older (as of June 2012)			
Race	**Female**	**Male**	**Total**
White	7,000	2,870	9,870
Other	886	384	1,270
Native American	347	158	505
Black	106	74	180
Asian	678	392	1,070
Pacific Islander	68	46	114
Total	**9,085**	**3,924**	**13,009**

Table 7

Medicaid Services

Medical services covered by Medicaid can be classified into six major service groups:

- Hospital Care – Inpatient and outpatient hospital services.
- Managed Care Organizations (MCOs) – Health plan-based services that provide a full range of inpatient and ambulatory medical services to enrolled Medicaid clients and reimbursed based on a monthly capitation rate or other federally approved methodology.
- Pharmacy – Prescription drug products.
- Long–term Care – Services provided to individuals who are either elderly or have a disability. Services can be provided in either an institutional or community-based setting.
- Physicians – All physician-delivered services.
- Other Care – Includes a wide range of medical services, such as vision care, home health care, rural health clinics and pre-natal care.

Hospital Care

Medicaid covers services performed in an inpatient setting at a hospital. There is an annual co-payment for inpatient services for non-emergent stays. Most outpatient services are covered on a referral basis and may be subject to prior approval.

Managed Care Organizations

There were 201,611 average monthly clients enrolled in Managed Health Care (MHC) in SFY 2012. MHC in Utah operates under federal 1915(b) freedom of choice waiver authority. The waiver allows the State to require Medicaid clients living in urban counties to select a health plan as their primary provider of care. MHC strives to decrease the unnecessary use of many health care services. A voluntary MHC program was expanded to rural communities in SFY 1988. Of clients under MHC, seven percent live in rural areas and 93 percent live in urban areas. Of the clients who were eligible for MHC in SFY 2012, 93 percent in the four urban counties were enrolled and 59 percent in the rural areas were enrolled either with a health plan or primary care provider.

Figure 8 illustrates the MHC eligible-client distribution for the past five state fiscal years and Figure 9 shows the total MHC care expenditures for the same five state fiscal years.

Techniques used to manage health care include the following: prior authorizations, case management, post-payment reviews, the 'Lock-In Program', the selection of a primary care physician and the MCO option mentioned above.

CARE DELIVERED THROUGH HEALTH PLANS

Managed Care includes services provided to recipients through contracts between the DMHF and health plans. DMHF contracted with three health plans in SFY 2012. The health plans provided comprehensive health care for 171,279 average monthly enrollees in SFY 2012, compared with 157,188 SFY 2011.

Figure 8 illustrates the managed health care eligible-client distribution for the past five fiscal years. These figures do not include clients receiving services in long-term care programs.

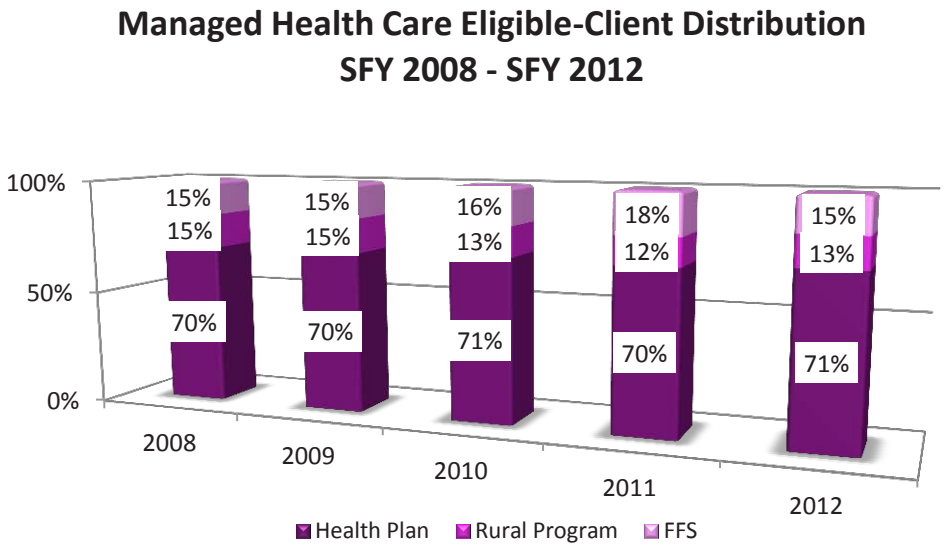


Figure 8

Figure 9 denotes total managed care expenditures for the past five fiscal years in millions of dollars.

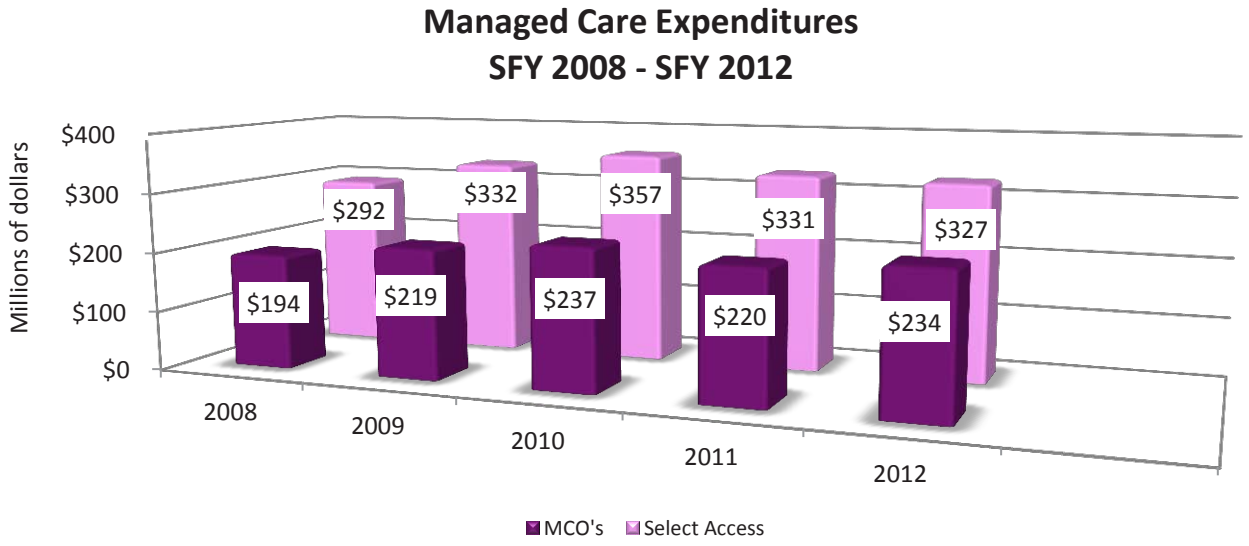


Figure 9

Pharmacy

Utah Medicaid provides coverage for nearly all available prescription drugs approved by the Food and Drug Administration (FDA).

To manage the costs of prescription drugs, Utah Medicaid has a generic-first requirement. If a generic product is available in a drug class and it is not more expensive than the brand name product, then the pharmacy must dispense the generic. If a generic brand for the drug does not exist, then a name brand is often used. Some prescriptions require prior approval.

Utah Medicaid also employs a Preferred Drug List (PDL) program with prior authorization. Following a determination of safety and efficacy by the Pharmacy and Therapeutics (P&T) Committee, preferred drugs are selected based upon recommendations by the P&T Committee and the net cost of the drugs. In many cases, the manufacturers of these products provide a secondary rebate to Medicaid.

Long-Term Care

Long-term care (LTC) is a variety of services that help meet the needs of people with a chronic illness or a disability. LTC services can be provided in home and community-based (HCBS) settings or nursing facilities. LTC accounted for 21 percent of the total Medicaid expenditures for SFY 2012.

NURSING HOME SERVICES

These services provide a full array of care on a 24-hour basis in licensed, skilled or intermediate care facilities including specialized facilities for people with intellectual disabilities. Services provided in the various facilities include: medical treatment to residents whose medical conditions are unstable and/or complex; medical treatment to residents whose medical conditions are stable but still require nursing care; supervision and assistance with daily living activities such as bathing, dressing and eating; and active treatment and health-related services to residents with intellectual disabilities in a supervised environment. Figure 10 shows the total expenditures in millions of dollars for the past five state fiscal years for nursing home services.

Figure 10 illustrates total nursing home expenditures for SFY 2008 – SFY 2012.

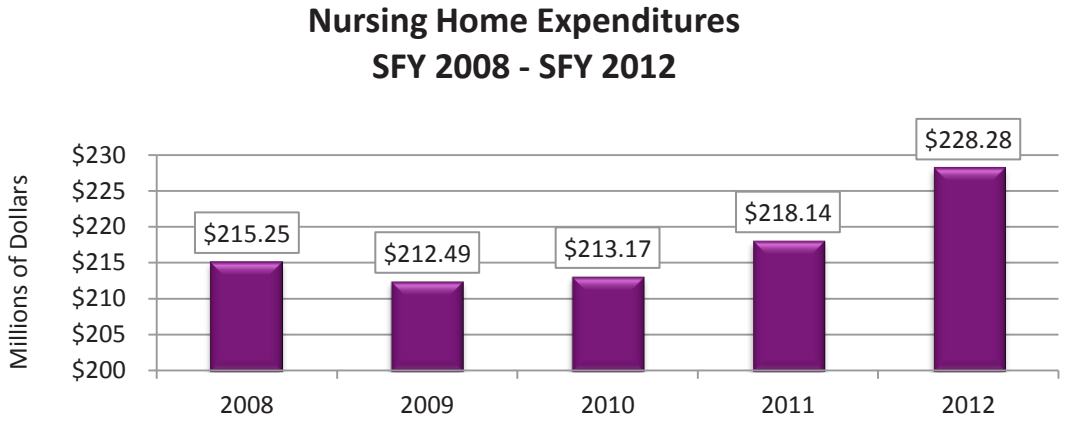


Figure 10

HOME AND COMMUNITY-BASED SERVICES (HCBS)

These programs provide LTC services in home and community-based settings as an alternative to nursing home services or services provided in an intermediate care facility. The day-to-day administration and state funding of four of the HCBS waivers is provided by the Department of Human Services. Utah currently has six HCBS waivers: Waiver for Individuals Aged 65 and Older, Waiver for Individuals with Acquired Brain Injuries, Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions, and the Waiver for Individuals with Physical Disabilities. The two remaining waivers, the New Choices Waiver and Technology Dependent Waiver, are managed internally and funded through Utah Medicaid. Utah Medicaid retains final administrative oversight of the HCBS waivers in its role as the State Medicaid Agency.

Figure 11 illustrates total home and community-based waiver expenditures for SFY 2008 through SFY 2012.

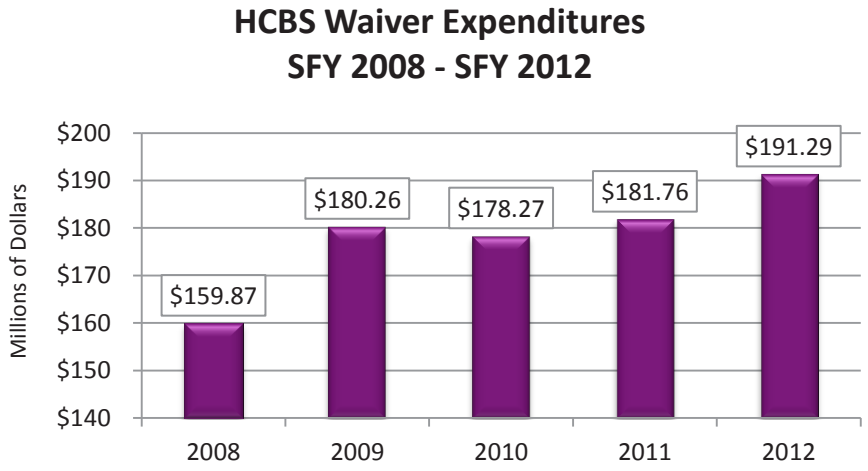


Figure 11

Waiver for Individuals Aged 65 and Older (Aging Waiver) – This program's primary focus is to provide services to elderly individuals in their own homes or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. DHS, the Division of Aging and Adult Services, oversees the day-to-day operation and provides the state funding for this program.

Waiver for Individuals with Acquired Brain Injuries – This program's primary focus is to provide services to adults who have sustained acquired brain injuries. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for nursing home care. DHS, Division of Services for People with Disabilities, oversees the day-to-day operation and provides the state funding of this program.

Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions – This program's primary focus is to provide services to children and adults with intellectual disabilities. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for services provided in an intermediate care facility for people with intellectual disabilities (ICF/ID). DHS, Division of Services for People with Disabilities, oversees the day-to-day operation and provides the state funding of this program.

Waiver for Individuals with Physical Disabilities – This program's primary focus is to provide services to adults who have physical disabilities. Services are provided in an individual's own home or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. DHS, Division of Services for People with Disabilities, oversees the day-to-day operation and provides the state funding of this program.

New Choices Waiver – The purpose of this waiver is to assist individuals who are currently residing in nursing facilities or licensed assisted living facilities to have the option to receive community-based services in the setting of their choice rather than in a nursing facility. Utah Medicaid oversees the day-to-day operations and provides the state funding for this program.

Technology Dependent Waiver – This program permits the State to furnish an array of home and community-based services (in addition to Medicaid State Plan services) necessary to assist technology dependent individuals with complex medical needs to live at home and avoid institutionalization. Responsibility for the day-to-day administration and operation of this waiver is shared by Utah Medicaid and the Division of Family Health and Prevention (also under the umbrella of the Single State Medicaid Agency). Utah Medicaid provides the state matching funds for this program.

HCBS Waiver Expenditures					
	2008	2009	2010	2011	2012
Acquired Brain Injury Waiver	$2,418,432	$2,451,418	$2,673,426	$2,642,635	$2,690,396
Aging Waiver	$3,953,052	$4,055,919	$3,489,938	$3,482,887	$4,142,338
Community Supports Waiver	$137,513,717	$151,048,396	$149,592,398	$149,681,699	$155,357,845
New Choices Waiver	$12,442,216	$18,794,047	$18,714,273	$21,688,927	$24,712,337
Physical Disabilities Waiver	$1,899,992	$2,037,421	$1,937,873	$1,889,854	$1,959,150
Tech Dependent Waiver	$1,639,151	$1,870,079	$1,856,179	$2,378,018	$2,425,176
TOTAL	**$159,868,568**	**$180,259,289**	**$178,266,097**	**$181,764,020**	**$191,287,242**

Table 8

DETERMINATION OF NEED

Prior to receiving a Medicaid payment, the Agency assures that each person receiving long-term care services, whether in nursing homes or HCBS waiver programs, has had an assessment performed and has been determined to require the level-of-care provided in the long-term care program for which they are applying. Individuals are then re-assessed on an annual or other routinely scheduled basis to assure the need for LTC services continues to exist.

Figure 12 shows the number of recipients who received services in HCBS waivers or received nursing home services in SFY 2012.

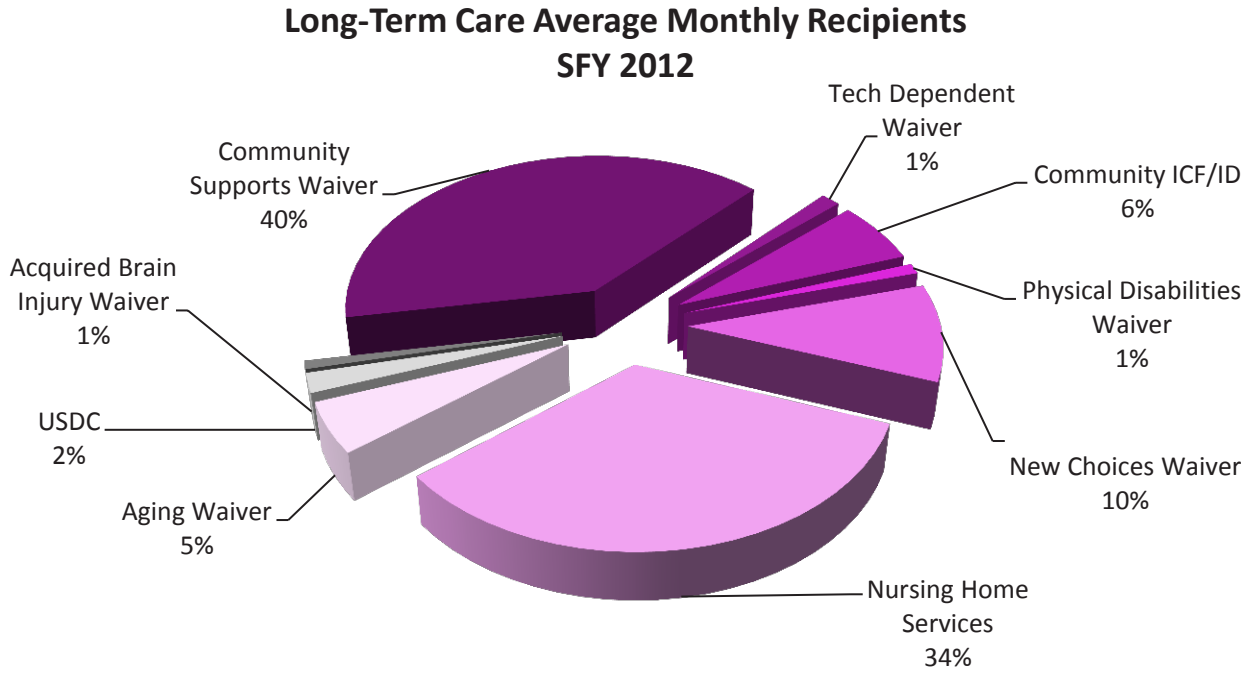


Figure 12

Medicaid Client Story:

One Medicaid client, Josh Rhees, is able to live a normal life because of a Medicaid waiver program that encourages people with disabilities to work and live independently. Josh has had a severe case of cerebral palsy since birth and must use his wheelchair to get around. He has no motor skills and relies on home health care to assist with the activities of daily living, like showering and dressing. Medicaid also provides Josh with transportation resources to and from work, which have helped him achieve a productive and fulfilling life.

Utah Medicaid Long Term Care Institutional & Non-Institutional State Fund Expenditure Comparison						
Fiscal Year	Institutional Total State Costs	Non-Institutional Total State Costs	Total Combined State Costs	Difference between Non-Institutional & Institutional Total	Institutional Percentage of Total Costs	Non-Institutional Percentage of Total Costs
2009	$64,525,555.46	$63,872,540.79	$128,398,096.25	($653,014.67)	50.25%	49.75%
2010	$62,385,972.21	$60,906,926.30	$123,292,898.51	($1,479,045.92)	50.60%	49.40%
2011	$64,543,652.17	$66,196,862.88	$130,740,515.05	$1,653,210.72	49.37%	50.63%
2012	$66,885,688.45	$66,681,249.66	$133,566,938.11	($204,438.79)	50.08%	49.92%

1 Although variable from year to year, Utah's FMAP rate is approximately a 70/30 percent match rate. For convenience, rather than using the precise annual percentages, we have reflected the State's share as 30% of total expenditures throughout the tables in this chart.
2 Institutional costs include nursing facility and ICF/ID expenditures.
3 Non-Institutional costs include home and community based waiver, personal care, private duty nursing and home health expenditures.
4 The State Fiscal 2012 year runs from July 1, 2011 through June 30, 2012. Because Medicaid providers have one year after the date of service in which to submit claims, the FY2012 expenditures reflected are not finalized numbers.

Table 9

Physician Services

Medicaid pays for each Medicaid eligible to see a Primary Care Provider (PCP) when the enrollee is having health problems. Most of the time treatment can be provided by the PCP in the office. If the PCP feels the problem is too serious to treat in the office, a referral is made to a specialist.

Providers

Medical services are provided to Medicaid clients by any willing provider who bills Medicaid directly. In SFY 2012 there were 11,794 fee-for-service (FFS) providers that directly billed Medicaid. Table 10 provides a unique count of providers by category of service.

Number of Participating FFS Providers by Category of Service

Category of Service	SFY 2012
Inpatient Hospital	192
Outpatient Hospital	397
Long-Term Care Facilities	108
Home Health Services	183
Personal Care Services	60
Substance Abuse Treatment Services	48
Independent Lab and/or X-Ray Services	110
Ambulatory Surgical Services	43
Contracted Mental Health Services	239
Mental Health Services	15
Rural Health Clinics	23
Kidney Dialysis	42
Pharmacy	580
Medical Supplies	481
Occupational Therapy	36
Medical Transportation	129
Specialized Nursing & Pediatrics	565
Well Child Care	603
Physician Services	3,835
Federally Qualified Health Centers	27
Dental	782
Psychologist Services	104
Physical Therapy	252
Speech and Hearing Services	88
Podiatrist	123
Vision Care	263
Optical Supplies	10
Osteopathic Services	373
QMB Services	21
Home & Community Based Waiver Services	835
Chiropractic Services	192
Targeted Case Management	28
Perinatal / Postnatal Care	30
Skills Development	33
Early Intervention	16
Buy-Out	1,316
TOTAL	**12,182**

Table 10

Recipients by County SFY 2012

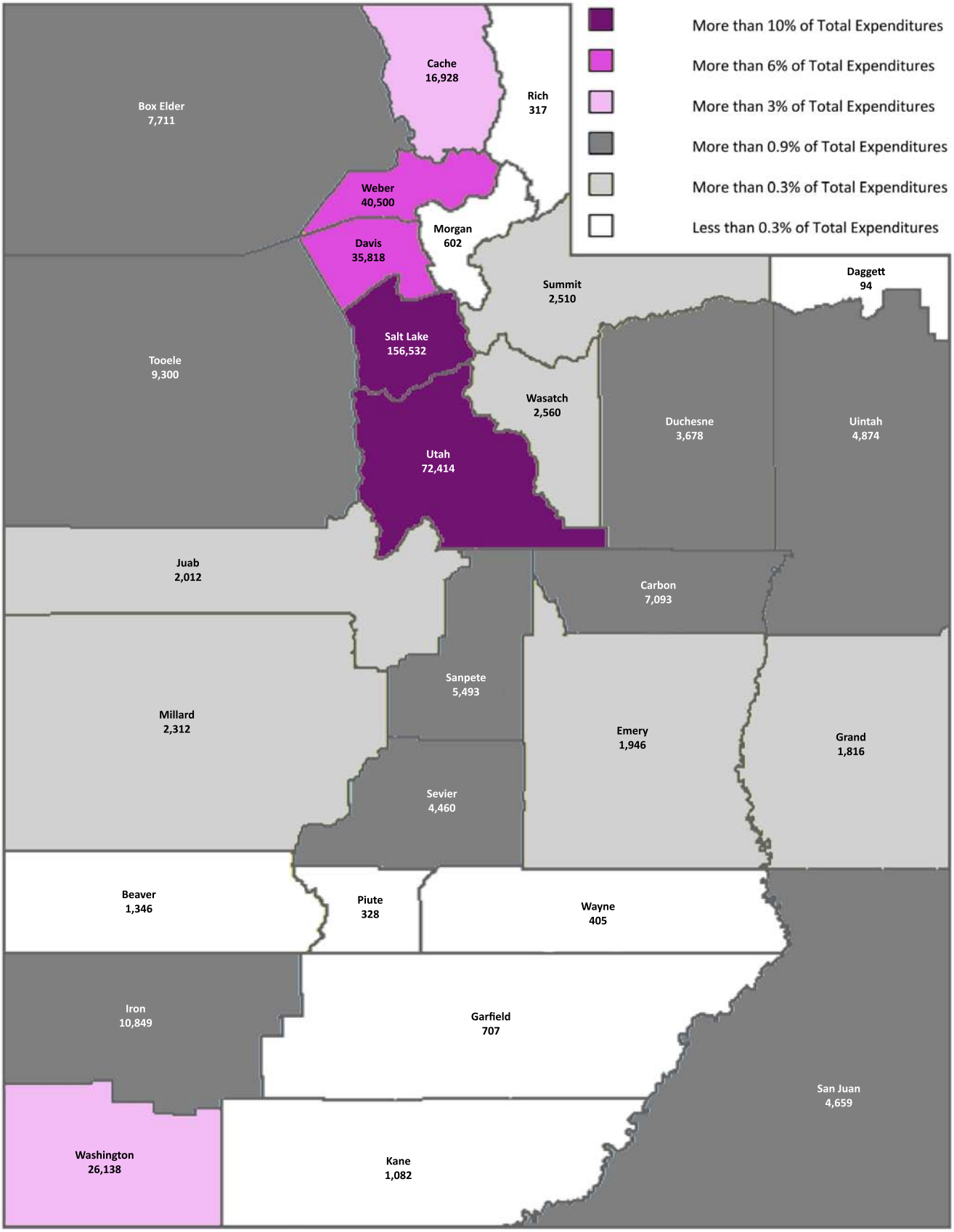


Table 11

Medicaid Expenditures by County and Service Group SFY 2012							
	Hospital Care	Managed Care	Pharmacy Services	Long-Term Care	Physician Services	Other Services	Grand Total
Beaver	$2,707,018	$35,887	$439,011	$1,098,713	$315,316	$823,911	$5,419,856
Box Elder	$10,814,077	$458,576	$3,315,944	$5,956,583	$2,550,238	$7,341,149	$30,436,567
Cache	$23,607,071	$264,666	$6,440,852	$13,813,387	$6,174,665	$13,824,339	$64,124,981
Carbon	$10,694,149	$3,058	$2,460,989	$6,082,142	$1,785,315	$5,319,696	$26,345,348
Daggett	$55,905	$169	$60,190	$0	$31,187	$30,350	$177,801
Davis	$24,778,116	$31,149,320	$16,629,330	$34,808,648	$5,206,778	$33,117,820	$145,690,012
Duchesne	$7,954,709	$39,269	$1,531,203	$4,224,802	$1,369,870	$3,043,552	$18,163,405
Emery	$2,676,359	$2,109	$839,504	$1,560,649	$478,056	$1,746,816	$7,303,494
Garfield	$1,172,041	$68,899	$386,597	$971,940	$132,534	$394,131	$3,126,142
Grand	$3,370,012	$74,645	$814,815	$1,311,570	$511,579	$1,571,667	$7,654,288
Iron	$11,956,067	$6,640,521	$4,402,219	$7,922,400	$2,258,195	$6,988,935	$40,168,338
Juab	$3,709,736	$50,519	$868,768	$2,694,192	$522,527	$1,917,592	$9,763,334
Kane	$1,749,137	$270,577	$303,937	$695,982	$173,917	$517,114	$3,710,664
Millard	$3,064,341	$21,504	$888,035	$2,152,334	$757,578	$1,186,690	$8,070,482
Morgan	$572,248	$183,051	$192,609	$145,650	$117,139	$396,252	$1,606,950
Out of State	$83,931	$0	$33,574	$2,754	$23,344	$103,941	$247,543
Piute	$201,284	$0	$157,788	$110,150	$59,017	$274,760	$802,999
Rich	$170,161	$2,020	$66,676	$87,803	$97,483	$208,757	$632,900
Salt Lake	$298,299,965	$127,876,129	$69,795,832	$145,281,176	$42,224,427	$151,022,118	$834,499,647
San Juan	$7,068,582	$18,280	$4,018,036	$4,088,727	$3,739,169	$3,232,150	$22,164,943
Sanpete	$7,006,583	$7,010	$2,467,589	$2,824,684	$1,572,723	$4,707,249	$18,585,839
Sevier	$6,765,837	$82,295	$2,150,294	$4,126,069	$1,409,527	$3,212,817	$17,746,839
Summit	$3,489,841	$118,070	$624,381	$776,732	$599,385	$1,607,510	$7,215,918
Tooele	$13,905,443	$2,881,674	$4,295,214	$3,136,848	$2,350,670	$8,229,407	$34,799,256
Uintah	$9,858,274	$55,615	$2,037,372	$5,083,380	$1,788,773	$3,631,640	$22,455,054
Utah	$85,544,668	$25,523,854	$30,953,857	$89,874,823	$17,694,194	$66,851,683	$316,443,078
Wasatch	$3,667,067	$35,**599**	$697,011	$1,814,010	$741,457	$1,307,064	$8,262,209
Washington	$29,898,724	$10,951,053	$7,942,569	$17,080,223	$6,305,475	$18,635,405	$90,813,450
Wayne	$581,463	$0	$154,125	$69,968	$119,303	$307,701	$1,232,561
Weber	$43,101,709	$27,456,207	$17,885,267	$34,738,355	$8,493,657	$30,926,712	$162,601,907
Grand Total	**$618,524,518**	**$234,270,576**	**$182,853,590**	**$392,534,694**	**$109,603,501**	**$372,478,926**	**$1,910,265,803**

Table 12

Medicaid Recipients by County and Service Group SFY 2012							
	Hospital Care (Unduplicated)	Managed Care (Unduplicated)	Pharmacy Services (Unduplicated)	Long-Term Care (Unduplicated)	Physician Services (Unduplicated)	Other Services (Unduplicated)	Total (Not Unduplicated)
Beaver	641	30	807	43	721	1187	3429
Box Elder	3,102	305	4,384	213	5,119	7,166	20,289
Cache	7,872	166	9,866	433	11,722	15,896	45,955
Carbon	3,143	8	3,039	218	4,936	4,857	16,201
Daggett	34	1	43	0	55	80	213
Davis	7,143	19,284	20,064	970	13,514	33,169	94,144
Duchesne	1,895	60	2,138	144	2,501	3,376	10,114
Emery	766	8	1087	72	1071	1771	4775
Garfield	323	60	396	38	379	598	1794
Grand	856	29	925	54	1114	1686	4664
Iron	3,554	3,539	6,251	254	5,275	9,991	28,864
Juab	884	36	1081	86	1281	1844	5212
Kane	427	151	550	31	512	981	2652
Millard	1,097	29	1,247	83	1,499	2,104	6,059
Morgan	162	109	318	13	330	553	1485
Out of State	53	0	64	1	69	343	530
Piute	141	0	207	8	206	275	837
Rich	118	7	187	6	166	289	773
Salt Lake	44,332	86,255	91,290	4,577	66,150	146,443	439,047
San Juan	1,603	14	2,646	200	3,325	4,153	11,941
Sanpete	2,491	27	3,076	144	3,638	4,987	14,363
Sevier	2,165	47	2,752	156	2,921	4,059	12,100
Summit	1051	156	1230	54	1498	2275	6264
Tooele	3,680	1,995	5,360	160	5,015	8,573	24,783
Uintah	2,443	131	2,790	146	3,180	4,511	13,201
Utah	22,933	19,907	40,626	2,206	40,071	68,307	194,050
Wasatch	1,185	50	1,356	66	1,776	2,180	6,613
Washington	8,968	7,187	14,376	650	13,703	24,466	69,350
Wayne	135	0	250	5	193	366	949
Weber	11,445	16,074	23,449	1,209	18,996	37,906	109,079
Total	**134,642**	**155,665**	**241,855**	**12,240**	**210,936**	**394,392**	**1,149,730**

Table 13

Medicaid Consolidated Report

All Medicaid money is administered by the Utah Department of Health (DOH). As per federal requirements, all funding for Medicaid must flow through the DOH and be governed by a memorandum of understanding for all functions performed by other entities whether state, non-profit, for profit, local government, etc.

Being the single state agency, DOH is ultimately responsible for all aspects of Medicaid and is prohibited from delegating its authority to those other than its own officials. DOH is required to exercise administrative discretion on the administration and supervision of the Medicaid State Plan, issue policies, rules, and regulations relating to Medicaid program matters.

Programs and services for Medicaid are delivered by DOH, the Departments of Human Services (DHS), the Department of Workforce Services (DWS) and a myriad of contracted providers including University of Utah Hospitals (U of U), local health organizations, not-for-profit entities, and for–profit entities. The Office of the Attorney General and the Office of Inspector General also receive Medicaid funding in their budgets to audit the Medicaid program, as well as identify, investigate and prosecute Medicaid fraud and abuse.

This consolidated report section shows how Medicaid appropriations are being spent for administration and services by the following departments: DOH, DHS, DWS, the University of Utah, the Office of Attorney General, and the Office of Inspector General. In addition, DOH passes funding through to local government and other providers. The Governor's Office of Planning and Budget reviews expenditure data from these six state agencies.

Figure 13 shows Medicaid funding by funding source. Federal funds comprise the largest share at 66 percent of total funding. Figure 14 shows all Medicaid expenditures for SFY 2012. Program expenditures totaled $2,065,453,600. Expenditures for mandatory services comprised the largest portion of total expenditures (51 percent) followed by optional services (44 percent). Specific detail is shown for both service expenditures and administrative expenditures. Administrative expenses accounted for $96 million, or 4.7 percent of the total Medicaid-related expenditures.

Table 15 shows Medicaid funding by source and type of service. In SFY 2012 federal funds provided the largest share of funds for both mandatory and optional services, totaling $1.4 billion.

Table 16 shows Medicaid expenditures by type of service. Inpatient hospital services incurred the largest share of mandatory services at $382,142,100, while pharmacy incurred the largest portion of optional services at $182,403,500.

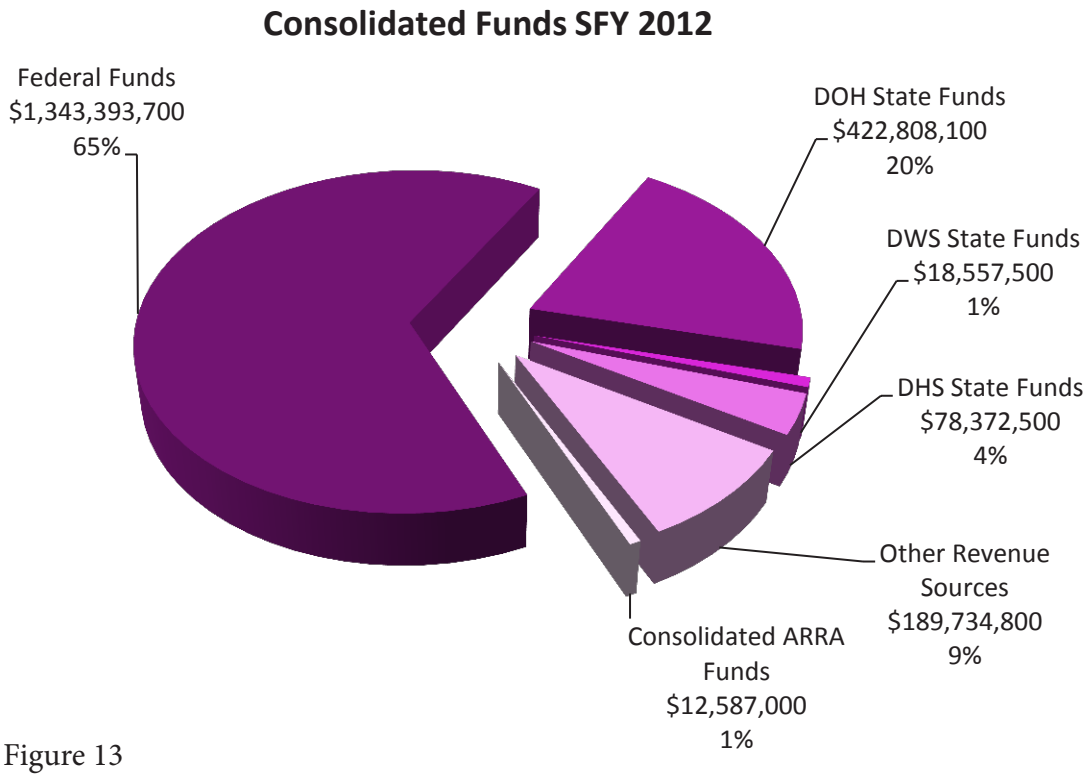


Figure 13

Other Revenue Sources SFY 2012	
Mental Health Services	$30,993,400
Substance Abuse	$2,765,400
Local Health Departments	$624,700
School Districts	$10,235,100
Family Health & Preparedness	$453,700
Healthy U Health Plan	$3,165,500
Health & Dental Clinics	$6,098,300
Pharmacy Rebates	$90,008,000
Physician Enhancement	$9,031,600
Inpatient UPL Payments	$19,106,500
Disproportionate Share Hospital	$9,229,000
Early Intervention	$175,800
PCN Enrollment Fees	$302,100
Refugee Relocation	$1,111,000
CHIP Allocation	$1,366,800
Disease Control and Prevention	$777,500
Center for Health Data	$185,000
DHS (Non-Medicaid)	$2,806,500
Other	$1,298,900
Total	**$189,734,800**

Table 14

Consolidated Medicaid Revenues FY2012

Mandatory	LHB	LHC	LHD	LHE	LHF	LHG	LHH	LHJ	LHK		Total
General Fund	$50,552,900	$31,626,600	$66,496,900	$27,403,700	$23,974,100	$15,792,500	$4,376,800	$4,492,800	$265,800		$224,982,100
Federal Funds	$275,257,700	$121,110,500	$161,265,600	$67,714,100	$58,537,200	$43,956,900	$10,034,000	$10,956,800	$249,200		$749,082,000
Dedicated Credits	$0	$0	$3,165,500	$548,200	$0	$1,058,900	$0	$0	$0		$4,772,600
Restricted Revenue	$41,500,000	$17,914,000	$0	$0	$0	$0	$0	$0	$0		$59,414,000
Transfers	$61,400	$0	$141,000	$155,300	$179,400	$2,345,900	$0	$4,400	$0		$2,887,400
Beginning Balance	($577,100)	$0	$0	$0	$0	$0	$0	$0	$0		($577,100)
Closing Balance	$15,266,700	$0	$0	$0	$0	$0	$0	$0	$0		$15,266,700
Lapsing Balance	$80,500	$0	$0	$0	$0	$0	$0	$0	$0		$80,500
	$382,142,100	$170,651,100	$231,069,000	$95,821,300	$82,690,700	$63,154,200	$14,410,800	$15,454,000	$515,000		$1,055,908,200

Optional	LJA	LJB	LJC	LJD	LJE	LJF	LJG	LJH	LJJ	LJK	LJL, LJM, & LJN	Total
General Fund	$18,123,700	$1,043,400	$4,508,600	$18,897,900	$11,425,800	$10,982,300	$655,900	$12,086,800	($3,713,700)	($4,176,800)	$41,582,700	$111,416,600
Federal Funds	$68,881,700	$115,526,900	$97,561,900	$22,298,100	$27,394,700	$51,024,500	$1,605,200	$57,645,200	$0	$78,916,300	$32,850,300	$553,704,800
Dedicated Credits	$90,008,000	$0	$31,024,900	$0	$0	$0	$0	$8,185,600	$0	$34,357,000	$2,290,200	$165,865,700
Restricted Revenue	$0	$0	$0	$0	$0	$2,741,100	$0	$0	$0	$0	$0	$2,741,100
Transfers	$254,100	$47,595,200	$5,814,100	$0	$17,500	$12,930,000	$4,600	$4,301,500	$3,713,700	$0	$0	$74,630,700
Beginning Balance	($7,010,200)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($7,010,200)
Closing Balance	$12,146,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$12,146,000
Lapsing Balance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	$182,403,300	$164,165,500	$138,909,500	$41,196,000	$38,838,000	$77,677,900	$2,265,700	$82,219,100	$0	$109,096,500	$76,723,200	$913,494,700

	Services	Admin	Total
General Fund	$336,398,700	$3,372,500	$339,771,200
Federal Funds	$1,302,786,800	$52,794,500	$1,355,581,300
Dedicated Credits	$170,638,300	$7,412,700	$178,051,000
Restricted Revenue	$62,155,100	$641,300	$62,796,400
Transfers	$77,518,100	$31,095,800	$108,613,900
Beginning Balance	($7,587,300)	$40,400	($7,546,900)
Closing Balance	$27,412,700	$693,500	$28,106,200
Lapsing Balance	$80,500	$0	$80,500
	$1,969,402,900	$96,050,900	$2,065,453,600

Table 15

Medicaid Expenditures FY2012							
Mandatory	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
Inpatient Hospital	$344,086,600	$0	$38,055,500	$0	$0	$0	$382,142,100
Nursing Home	$170,651,100	$0	$0	$0	$0	$0	$170,651,100
Contracted Health Plan Services	$225,248,700	$0	$5,820,300	$0	$0	$0	$231,069,000
Physician Services	$89,887,000	$0	$5,934,300	$0	$0	$0	$95,821,300
Outpatient Hospital	$69,388,500	$0	$13,302,200	$0	$0	$0	$82,690,700
Crossovers	$7,447,900	$0	$6,962,900	$0	$0	$0	$14,410,800
Medical Supplies	$15,454,000	$0	$0	$0	$0	$0	$15,454,000
State Run PCCM	$515,000	$0	$0	$0	$0	$0	$515,000
Other Mandatory Services	$63,154,200	$0	$0	$0	$0	$0	$63,154,200
Subtotal	$985,833,000	$0	$70,075,200	$0	$0	$0	$1,055,908,200
Optional	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
Pharmacy	$182,403,500	$0	$0	$0	$0	$0	$182,403,500
Home & Community Based Waivers	($4,173,800)	$168,339,300	$0	$0	$0	$0	$164,165,500
Other Optional Services - DOH							
HCBS	$27,137,500	$0	$0	$0	$0	$0	$27,137,500
Mental Health Services	$133,152,000	$5,757,500	$0	$0	$0	$0	$138,909,500
Buy In / Out	$41,196,000	$0	$0	$0	$0	$0	$41,196,000
Dental Services	$38,838,000	$0	$0	$0	$0	$0	$38,838,000
Intermediate Care Facilities	$35,510,600	$42,167,300	$0	$0	$0	$0	$77,677,900
Vision Care	$2,196,100	$0	$69,600	$0	$0	$0	$2,265,700
Hospice Care Services	$13,948,800	$0	$0	$0	$0	$0	$13,948,800
Other Optional Services	$55,070,600	$0	$10,900	$0	$0	$0	$55,081,600
Non-Service Expenditures	$38,936,500	$0	$0	$0	$0	$0	$38,936,500
Disproportionate Share Hospital	$0	$0	$34,060,700	$0	$0	$0	$34,060,700
Clawback Payments	$0	$0	$28,713,700	$0	$0	$0	$28,713,700
Graduate Medical Education	$1,674,200	$0	$4,662,300	$0	$0	$0	$6,336,500
Inpatient UPL Payments	($2,535,000)	$0	$54,613,300	$0	$0	$0	$52,078,300
UUMG Physician Enhancement	$0	$0	$11,745,100	$0	$0	$0	$11,745,100
Subtotal	$563,355,000	$216,264,100	$133,875,600	$0	$0	$0	$913,494,700
Administrative	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
	$38,569,200	$16,613,600	$0	$37,115,000	$1,715,300	$2,037,600	$96,050,700
Total Expenditures	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
	$1,587,757,200	$232,877,700	$203,950,800	$37,115,000	$1,715,300	$2,037,600	$2,065,453,600

Note that for this report the 'Other Optional Services' appropriation was divided into two categories, 'Other Optional Services – DOH HCBS' and 'Other Optional Services'. The New Choices Waiver and Technology Dependent Waiver expenditures are being reported under 'Other Optional Services – DOH HCBS'; whereas the remaining Other Optional Services are reported under 'Other Optional Services'.

Table 16

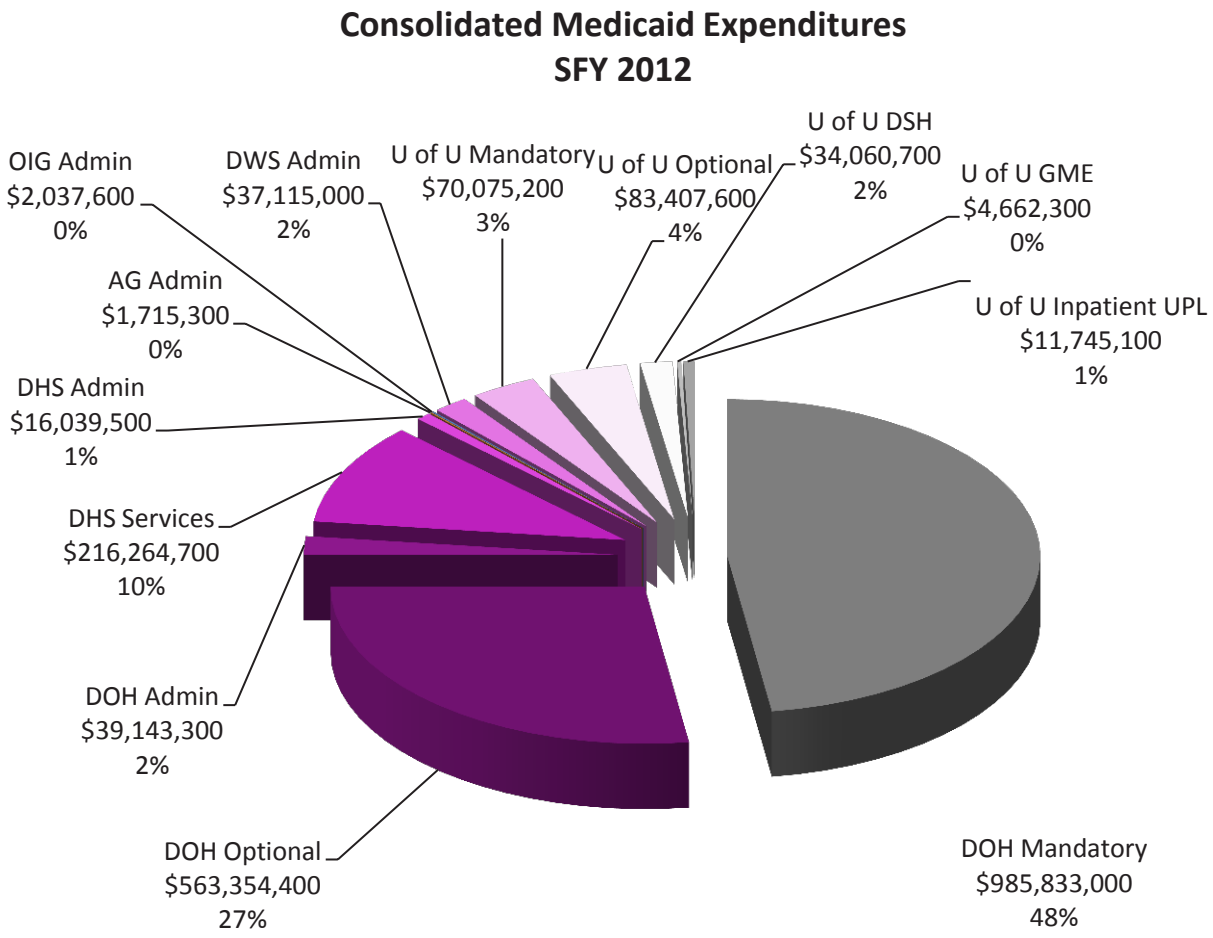


Figure 14

Utah Department of Health - Division of Medicaid and Health Financing

The Utah Department of Health (DOH) was created in 1981 to protect the public's health by preventing avoidable illness, injury, disability and premature death; assure access to affordable, quality health care; promote healthy lifestyles; and monitor health trends and events.

The Division of Medicaid and Health Financing (DMHF) administers the Medicaid program under the direction of the Utah Department of Health. The Medicaid program makes up 72 percent of the total DOH budget. See the Division of Medicaid and Health Financing (DMHF) overview on page 2 of this report for a breakdown of the bureau responsibilities within the DOH/DMHF. Table 17 shows Medicaid expenditures managed within the DOH (77 percent of the total Medicaid expenditures) by mandatory and optional services, and by administrative costs. Administrative expenditures were $39.1 million, or 2 percent of total Medicaid expenditures. This amount does not include eligibility determination, which is done by the DWS. Please note that HCBS Waivers in Table 16 do not include the New Choices Waiver or Technology Waiver (see note below Table 16).

Utah Department of Health - Division of Medicaid and Health Financing

Service Expenditures - Actual		
Mandatory	***Total Exp***	***Percent of Total***
Inpatient Hospital	$344,086,600	21%
Nursing Home	$170,651,100	11%
Contracted Health Plan Services	$225,248,700	14%
Physician Services	$89,887,000	6%
Outpatient Hospital	$69,388,500	4%
Crossovers	$7,447,900	<1%
Medical Supplies	$15,454,000	<1%
State Run PCCM	$515,000	<1%
Other Mandatory Services	$63,154,200	4%
Total Mandatory	**$985,833,000**	**61%**
Optional	***Total Exp***	***Percent of Total***
Pharmacy	$182,403,5000	11%
Home & Community Based Waivers	($4,173,900)	<1%
Mental Health Services	$133,151,500	8%
Buy In / Out	$41,196,000	3%
Dental Services	$38,838,000	2%
Intermediate Care Facilities	$35,510,600	2%
Vision Care	$2,196,100	<1%
Other Optional Services	$161,272,000	8%
Disproportionate Share Hospital	$7,557,300	<1%
Graduate Medical Education	$1,674,200	<1%
Total Optional	**$599,625,300**	**37%**
Total Service Expenditures DOH/DMHF	**$1,585,458,300**	**98%**

Administrative Expenditures - Actual		
Responsibilities:		
Claims payment, rate setting, cost settlement, contracting, prior authorization of services, waiver management, client plan selection.		
	Total Exp	***Percent of Total***
Personal Services	$13,131,400	<1%
Travel - In State	$17,450	<1%
Travel - Out of State	$22,650	<1%
Current Expense	$5,841,200	<1%
Data Processing Current Expense	$7,778,600	<1%
Capital Outlay	$309,600	<1%
Other Charges/Pass Through	$12,042,500	<1%
UDOH/DMHF Total Admin Expenditures	**$39,143,400**	**2%**
TOTAL	**$1,624,601,600**	**100%**

Total UDOH Budget	**$2,249,424,500**
Medicaid as a % of Overall Budget	**72%**

Table 17

Department of Human Services

The Department of Human Services (DHS) was created in 1990 under UCA 62A-1-102 to provide direct and contracted social services to persons with disabilities, children and families in crisis, juveniles in the criminal justice system, individuals with mental health or substance abuse issues, vulnerable adults, and the aged.

Table 18 shows Medicaid expenditures by DHS by category of service and funding source, as well as administrative costs. The largest portion of service funds was expended on people with disabilities - just under $135 million in federal funds and $55 million from the state funds - and accounts for more than 82 percent of total DHS services expenditures. Administrative costs were $16 million, or 6.9 percent of total Medicaid expenditures by DHS.

In SFY 2012, the DHS total budget was $671 million, of which $233 million was expended on Medicaid, or about 35 percent of the total DHS budget.

Department of Human Services

Service Expenditures – Actual (through DHS)				
	Federal Funds	*State Funds*	*Total*	*Percent of Total*
People with Disabilities	$134,690,500	$54,987,000	$189,677,500	81.4%
Utah State Hospital	$11,286,700	$4,616,200	$15,902,900	6.8%
Total Service Expenditures DHS	**$145,977,200**	**$59,603,200**	**$205,580,400**	**88.3%**

Administrative Expenditures - Actual				
	Federal Funds	*State Funds*	*Total*	*Percent of Total*
Total Administrative Expenditures DHS	$8,528,000	$8,085,600	$16,613,600	7.1%

Service Expenditures – Direct Billed to DOH (State participation from DHS to DOH)		
	Total	*Percent of Total*
Child and Family Services	$4,177,000	1.8%
Juvenile Justice System	$1,580,500	0.7%
Substance Abuse and Mental Health	$3,713,700	1.6%
Aging and Adult Services	$1,212,500	0.5%
Total Service Expenditures DHS	**$10,683,700**	**4.6%**
TOTAL Expenditures	**$232,877,700**	**100%**

Total DHS Budget	**$670,675,800**
Medicaid as a % of overall budget	**35%**

Based on SFY cutoff period actual transfers.

Table 18

Divisions within DHS, which affect services within the Medicaid expenditures, are as follows:

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

The mission for the Division is to promote opportunities and provide support for persons with disabilities to lead self-determined lives.

DIVISION OF CHILD AND FAMILY SERVICES

The mission of the Division of Child and Family Services (DCFS) is to protect children at risk of abuse, neglect, or dependency. The Division does this by working with families to provide safety, nurturing, and permanence.

The Division partners with the community in this effort.

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

The Division is responsible for ensuring that substance abuse and mental health services are available statewide. A continuum of substance abuse services that includes prevention and treatment is available for adults and youth. The goal is to ensure that treatment is available for adults with serious mental illness and for children with serious emotional disturbance. Services are offered statewide through 13 local authorities who either provide services or contract with private providers.

OFFICE OF RECOVERY SERVICES

The Office of Recovery Services (ORS) serves children and families by promoting independence through responsible parenthood and ensures public funds are used appropriately, which reduces costs to public assistance programs. ORS works with parents, employers, federal, state and private agencies, professional associations, community advocates, the legal profession and other stakeholders and customers. The office works within the bounds of state and federal laws and limited resources to provide services on behalf of children and families.

The Office provides services to reimburse the State for costs of supporting children placed in its care and/or custody. Financial and medical support is obtained by locating parents, establishing paternity and support obligations, and enforcing those obligations when necessary. The Office also collects medical reimbursement from responsible third parties to reimburse the State and avoid additional Medicaid costs.

DIVISION OF AGING AND ADULT SERVICES

The Division provides leadership and advocacy pertaining to issues that impact older Utahns, and serves elderly and disabled adults needing protection from abuse, neglect or exploitation. The Division offers choices for independence by facilitating the availability of a community-based independent living in both urban and rural areas of the state. The Division encourages citizen involvement in planning and delivering services.

CHILD PROTECTION OMBUDSMAN

The Child Protection Ombudsman investigates consumer complaints regarding DCFS, and assists in achieving fair resolution of complaints, promoting changes that will improve the quality of services provided to the children and families of Utah, and building bridges with partners to effectively work for the children of Utah.

OFFICE OF FISCAL OPERATIONS

The Office establishes sound fiscal practices, which provide useful information, and maintains reliable program and fiscal controls.

OFFICE OF PUBLIC GUARDIAN

The Office provides court-ordered guardian and conservator services to incapacitated adults who are unable to make basic daily living or medical decisions for themselves. The Office provides training and education to health and social services professionals, as well as the general public on the services available and appropriate criteria to look for in determining alternatives to court ordered public guardianship/conservatorship is available. The Office conducts intakes and assessments for court petition processes.

OFFICE OF SERVICES REVIEW

The Office of Services Review assesses whether DCFS is adequately protecting children and providing appropriate services to families. The Office accomplishes this by conducting in-depth reviews of practice, identifying problem areas, reporting results and making recommendations for improvement to DCFS. The Office performs similar functions for other divisions and offices in the Department.

UTAH STATE HOSPITAL

Utah State Hospital is a 24-hour inpatient psychiatric facility which serves people who experience severe and persistent mental illness. It has the capacity to provide active psychiatric treatment services to 359 patients (including a five-bed acute unit). The hospital serves all age groups and all geographic regions of the state.

DIVISION OF JUVENILE JUSTICE SERVICES

The Division of Juvenile Justice Services (JJS) serves youth offenders with a comprehensive array of programs, including home detention, secure detention, day reporting centers, case management, community alternatives, observation and assessment, long-term secure facilities, transition, and youth parole. JJS is a division within the DHS but has been assigned to the Executive Offices and Criminal Justice Appropriations Subcommittee for Legislative oversight. Prior to SFY 2004, it was known as the Division of Youth Corrections.

JJS is responsible for all youth offenders committed by the State's Juvenile Court for secure confinement or supervision and treatment in the community. JJS also operates receiving centers and youth services centers for non-custodial and non-adjudicated youth.
Programs within JJS include:

- Administration
- Early Intervention Services
- Community Programs
- Correctional Facilities
- Rural Programs
- Youth Parole Authority (the JJS equivalent to the Board of Pardons and Parole)

Department of Workforce Services

The Department of Workforce Services (DWS) was created in 1997, per UCA 35A-1-103(1), to provide employment and support services for customers to improve their economic opportunities. Costs of DWS for the Eligibility Services Division are computed by taking a random moment time sample. On a quarterly basis, eligibility workers in the Department record the time they spent on fourteen public assistance programs. Total costs are allocated to the various programs based on the percent of time derived from the sample.

Table 19 shows DWS Medicaid administrative expenditures in SFY 2012 by cost type and funding source. Administrative costs totaled $37.1 million, or 5 percent of the DWS total budget of $755.7 million.

Department of Workforce Services

Administrative Expenditures - Actual				
	Federal Funds	*State Funds*	*Total*	*Percent of Total*
Direct Costs	$1,367,300	$1,367,300	$2,734,600	7%
Allocated Costs	$17,190,200	$17,190,200	$34,380,400	93%
DWS Total Admin Expenditures	**$18,557,500**	**$18,557,500**	**$37,115,000**	**100%**

Total DWS Budget	**$755,738,600**
Medicaid as a % of overall budget	**5%**

Table 19

Divisions and budget areas within DWS are as follows:

ELIGIBILITY SERVICES DIVISION

The Division was created in 2009 to centralize the State's public assistance eligibility process using eREP to process applications. The Division determines eligibility for the Medicaid, CHIP, and other federal and state public assistance programs.

Eligibility for the different medical programs varies depending upon the program. Some major elements of consideration include: income level, assets, and the presence of dependents in the home. Generally, those who receive coverage must submit documentation annually to confirm continued eligibility.

MEDICAL PROGRAMS

Medical Programs is a specific budget area at DWS and includes Medicaid, CHIP, PCN, and UPP eligibility. The entire eligibility component of these programs was transferred from DOH to DWS in SFY 2008. Prior to that, DWS conducted about 40 percent of all eligibility determinations. General administration and oversight of the programs are still conducted within DOH.

Medical Programs are funded by General Fund and Federal Funds for Medicaid, CHIP, PCN and UPP. DWS receives funding to provide eligibility determinations within each of the programs. Actual payments to providers are made by DOH.

MEDICAL PROGRAMS PERFORMANCE MEASURES

Program performance is measured by several mechanisms. Federal regulation requires that a decision be made on a medical application within 45 days following the date of application and 90 days for Disabled Medicaid. However, federal policy allows extensions for the applicant to provide proof of eligibility. DWS has established a timeliness benchmark of 30 days for its internal processes, similar to other DWS administered programs, such as the Supplemental Nutritional Assistance Program (formerly known as Food Stamps).

Approximately 28 percent of DWS time is related to the Medicaid program. As shown in Table 19, only six percent of the costs are direct, while 94 percent are allocated based on the random moment time study.

Office of the Attorney General

The Criminal Prosecution Program consists of five divisions of which two, criminal justice and investigations are responsible for investigation and prosecution of Medicaid fraud within the state. Table 20 shows Medicaid administrative expenditures by category and funding source. Total Medicaid expenditures comprise three percent of the Office of the Attorney General's budget.

Table 20 shows the Office of the Attorney General Medicaid Expenditures for SFY 2012.

Office of the Attorney General

Administrative Expenditures - Actual				
	Federal Funds	*State Funds*	*Total*	*Percent of Total*
Personnel Services	$852,500	$284,200	$1,136,700	66%
Travel	$9,400	$3,100	$12,500	<1%
Current Expense	$218,600	$72,800	$291,400	17%
Data Processing Current Expense	$15,900	$5,300	$21,200	1%
Indirect Costs	$187,000	$66,500	$253,500	15%
AG Total Administrative Expenditures	**$1,283,400**	**$431,900**	**$1,715,300**	**100%**

Total AG	**$60,411,300**
Medicaid as a % of overall budget	**3%**

Table 20

Office of the Inspector General

The Office of Inspector General (OIG) is an independent office of program evaluation and review located within the Governor's Office of Planning and Budget (GOPB). The purpose of this office is to ensure adequate internal controls are in place and effective policies and procedures are established and followed. The OIG focuses exclusively on the Medicaid program and all of their expenditures are related to Medicaid.

Office of the Inspector General

Administrative Expenditures - Actual			
	Federal Funds	*State Funds*	*Total*
OIG Total Administrative Expenditures	**$1,198,900**	**$838,700**	**$2,037,600**

Table 21

University of Utah Medical Center

The University of Utah is involved in three Medicaid program areas:

1. Inpatient Disproportionate Share Hospital – These funds come from finite federal allocation to states and are used to pay hospitals that serve a disproportionate share of Medicaid and uninsured patients. The funds are intended to offset some of the hospitals costs in serving these clients.

2. Direct Graduate Medical Education (GME) – These funds offset some of the costs of residency programs that serve Medicaid clients. The funds cannot be used for academic programs but are used to cover some of the patient care costs associated with the care provided by residents. These funds are subject to the calculated Upper Payment Limit (UPL) authorized by CMS.

3. Inpatient Upper Payment Limit (UPL) Supplemental Payments– These funds reimburse the providers up to the Medicare upper limit. The funds help offset some of the clinical care costs. All of the UPL funds are matched by the University and are subject to the calculated UPL as authorized by CMS.

Table 22 shows where the University of Utah expends Medicaid funds in SFY 2012. Expenditures for optional services comprise 58 percent of all University Hospital Medicaid expenditures, while mandatory services comprise the remaining 42 percent. Of mandatory services, the single largest expenditure is $38 million for inpatient services or 23 percent of all University of Utah Medicaid expenditures.

University of Utah Medical Center

Service Expenditures - Actual		
Mandatory	***Total***	***Percent of Total***
Inpatient Services	$38,055,500	22%
Contracted Health Plan	$5,820,300	3%
Physician Services	$5,934,300	4%
Outpatient Hospital	$13,302,200	8%
Other Mandatory Services	$6,962,900	4%
Total Mandatory	**$70,075,200**	**42%**
Optional	***Total***	***Percent of Total***
Vision Care	$69,600	<1%
Disproportionate Share Hospital	$26,503400	16%
Graduate Medical Education	$4,662,300	3%
Inpatient UPL Payments	$54,613,300	33%
UUMG Physician Enhancement	$11,745,100	7%
Other Optional Services	$11,000	<1%
Total Optional	**$97,604,700**	**58%**
U of U Total Service Expenditures	**$175,237,200**	**100%**

Table 22

Children's Health Insurance Program

The Utah Department of Health (DOH) manages the Children's Health Insurance Program (CHIP) through the Division of Medicaid and Health Finance (DMHF), the same division that manages Utah's Medicaid program. All eligibility actions are handled through the Department of Workforce Services (DWS).

CHIP is a state-sponsored, health insurance plan for uninsured children whose parents' income is 200 percent or less of the federal poverty level (FPG). In 2012, this limit is equal to $46,100 in annual income for a family of four.

Since being signed into law in 1998, CHIP has covered more than 256,000 Utah children, making it possible for them to get preventive care to stay healthy and medical services when they get sick or injured. In accordance with Section 26-40-106, Utah Code Annotated, CHIP benefits were actuarially equivalent during fiscal year 2012 to benefits received by enrollees in Select Health's Small Business Account plan, the commercial plan with the largest enrollment in the State. In SFY 2012 CHIP contracted with two HMO plans to provide medical services, Molina Healthcare of Utah and SelectHealth.

CHIP contracted with two dental providers, Premier Access and DentaQuest, to provide dental services for all CHIP enrollees. Premier Access is available statewide, while DentaQuest is available in Salt Lake, Weber, Davis, and Utah counties.

Finance

MEANS OF FINANCE

CHIP receives approximately 80 percent of its funding from the federal government under Title XXI of the Social Security Act with the other 20 percent coming from state matching funds. From SFY 2001 to SFY 2007, state funds came exclusively from the proceeds of the Master Settlement Agreement between the State and Tobacco companies. In SFY 2008 to SFY 2012, the state funding also included an appropriation from the General Fund.

- For SFY 2001, the Legislature appropriated $5.5 million from Tobacco Settlement funds in State match.
- For SFY 2004, the Legislature increased CHIP funding to $7.0 million to cover more children on the program and to restore dental services.
- For SFY 2006, the Legislature increased the state share of CHIP funding to $10.3 million to cover more children on the program.
- For SFY 2008, the Legislature added $2.0 million in ongoing General Fund and $2.0 million in one-time Tobacco Settlement Restricted Fund to cover more children on the program. For SFY 2008 the total appropriation of state funds was $14.3 million ($12.3 million in Tobacco Settlement Restricted Fund and $2.0 million in General Fund).
- For SFY 2009, the total appropriation in state funds is $14.3 million ($10.3 million in Tobacco Settlement Restricted Fund, $2.0 million in General Fund and an expected $2.0 million in carryover from SFY 2008).
- For SFY 2010, the Legislature decreased the ongoing General Fund to $0.5 million and increased the Tobacco Settlement Restricted Fund to $14.1 million to cover the loss in the General Fund. The program also has $2.9 million in carryover from SFY 2009.
- For SFY 2011, the Legislature appropriated an additional $2.4 million in General Fund for a total of $2.9 million. This appropriation was due to a shortfall in the Tobacco Settlement Restricted Fund. The

Tobacco Settlement Restricted Fund appropriation was reduced to $11.7 million. The program was not allowed to carry forward the $2.9 million from SFY 2009. However, the program was allowed to carry forward $0.6 million into SFY 2012 through non-lapsing authority.

- For SFY 2012, the Legislature appropriated an additional $3.0 million of one-time General Fund dollars for a total of $4.9 million. This appropriation was due to a shortfall in the Tobacco Settlement Restricted Fund. The Tobacco Settlement Restricted Fund appropriation was reduced to $11.1 million. The program was allowed to carry forward the $0.6 million from SFY 2011. The program was also allowed to carry forward $2.9 million into SFY 2013 through non-lapsing authority.

CHIP EXPENDITURES

For SFY 2012, CHIP spent $66.8 million on health plan premiums and $6.7 million on administration (see Table 23). The average monthly enrollment in CHIP was 37,936 in SFY 2012, the average cost per child was $1,938 per year, or $161 per month.

Table 23 shows CHIP expenditures in SFY 2012.

CHIP

Service Expenditures - Actual	TOTAL	Percent of Total
Capitated Managed Health Care		
SelectHealth	$33,302,400	45%
Molina	$21,228,600	29%
Dental Services		
Premier Access	$7,795,400	11%
DentaQuest	$1,439,800	2%
Immunization Services	$1,573,500	2%
Other Services	$1,032,000	1%
Total CHIP Services	**$66,371,700**	**90%**
UPP Services	**$420,100**	**1%**
Total Service Expenditures	**$66,791,800**	**91%**
Administrative Expenditures		
DOH	$4,292,600	6%
DWS	$2,426,200	3%
Total Administrative Expenditures	**$6,718,800**	**9%**
TOTAL	**$73,510,600**	**100%**

Table 23

COST SHARING & BENEFITS

In SFY 2012, families paid a premium of up to $75 per quarter for enrollment in CHIP. The amount of premium varied depending upon a family's income. Native American families and families with incomes below 100 percent FPG do not pay quarterly premiums. As of July 1, 2009, premiums for families from 151 to 200 percent FPG increased from $60 to $75. In addition, the Department began charging a $15 late fee if families failed to pay their premiums on time. In SFY 2012, CHIP collected $2 million in premiums and late fees. Premiums are used to fund the CHIP program and are appropriated as dedicated credit in the annual CHIP budget.

In FY 2012, most CHIP families paid co-payments in addition to their quarterly premiums. Native American families do not pay co-payments. As established in federal regulations, no family on CHIP is required to spend more than five percent of their family's annual gross income on premiums, co-payments and other out-of-pocket costs combined during their eligibility certification period.

Federal guidelines allow states to select from several options in creating a benchmark for CHIP coverage. As of July 1, 2008, CHIP moved to a commercial health plan benefit for its benchmark. In addition, as of July 1, 2010, CHIP adopted the commercial benefits for its dental benchmark.

MAJOR BUDGET CATEGORIES

Medical – CHIP contracts with two different managed care organizations. Both providers are full risk providers, offering a comprehensive medical coverage plan with CHIP funds paying the cost of a monthly capitated rate.

Dental – CHIP utilizes two providers to manage the dental program. Both providers are risk-based with CHIP funds paying a monthly capitated rate for dental coverage.

Utah's Premium Partnership for Health Insurance (UPP) - UPP is an effort to offer families a rebate when they enroll their children in their employer-sponsored health plan rather than CHIP. The current rebate is up to $120 per child per month for medical coverage and an additional $20 per month for dental coverage.

Enrollment

ELIGIBILITY REQUIREMENTS AND THE ENROLLMENT PROCESS

As required by House Bill 326 (2008), CHIP does not close enrollment and continuously accepts new applications. Applications for CHIP and UPP can be submitted through the mail, in-person, and online. A simplified renewal form and process is used to reduce unnecessary barriers for the families being served.
Basic eligibility criteria:

1. Gross family income cannot be higher than 200 percent FPG (for a family of four, 200 percent FPG is $46,100).
2. The child must be a resident of the state of Utah, and a U.S. citizen or legal alien.
3. The child must be 18 years of age or younger.
4. The child must be uninsured and not eligible for Medicaid.

CHIP children are enrolled in the program for a twelve-month period. CHIP contracted with two health plans in FY 2012 to provide medical service for enrollees:

1. Molina Healthcare of Utah
2. SelectHealth

CHIP contracted with Premier Access and DentaQuest in FY 2012 to provide dental services for all enrollees. Premier Access is available statewide. DentaQuest is available in Salt Lake, Weber, Davis, and Utah counties.

ENROLLMENT STATISTICS

As of August 2012, there were 36,725 children enrolled in CHIP. Of these enrollees, the ethnicity, race, age and income breakdowns are as follows:

Ethnicity	
Hispanic	9,191
Non-Hispanic	27,534
Race	
White	30,920
Multiple Races	4,045
Asian	544
Native American/Alaska Native	490
Black	415
Native Hawaiian/Pacific Islander	311
Age	
Less than 10	17,755
10 to 19	18,970
Income	
Less than 100% FPG	13,883
101% to 150% FPG	14,174
151% to 200% FPG	8,394
UPP	274

Sixty-nine percent of CHIP children are residents of Davis, Salt Lake, Weber, and Utah counties. Thirty-one percent are residents of other counties.

After a period of steady enrollment increases, enrollment in CHIP declined in FY 2011 and continued to decline in FY 2012. Data indicates that approximately 33 percent of children who were eligible for CHIP became eligible for Medicaid in SFY 2011. This can be attributed to the downturn in the economy. It is unclear of other causes for the enrollment to decrease; however, the following issues may have contributed to the decline:

1. Transfer of the premium collection process to DWS
2. Parents of children from mixed immigration households are hesitant to apply for CHIP or renew their children's CHIP case
3. The DWS eligibility business model may be a barrier to enrollment, premium payment and retention

CHIP Client Story:

As a single mother, Jasmine purchased private insurance for her family; however some months the premium was more than half of her income. Making the difficult choice to drop her insurance, Jasmine had no idea how much they would need it when her 12-year-old son was diagnosed and hospitalized with Type 1 Diabetes. Thankfully, hospital staff helped Jasmine apply for CHIP. "I wouldn't have been able to afford the hospital stay or his diabetic supplies without CHIP," said Jasmine.

Figure 15 shows enrollment since CHIP was re-opened in July 2007.

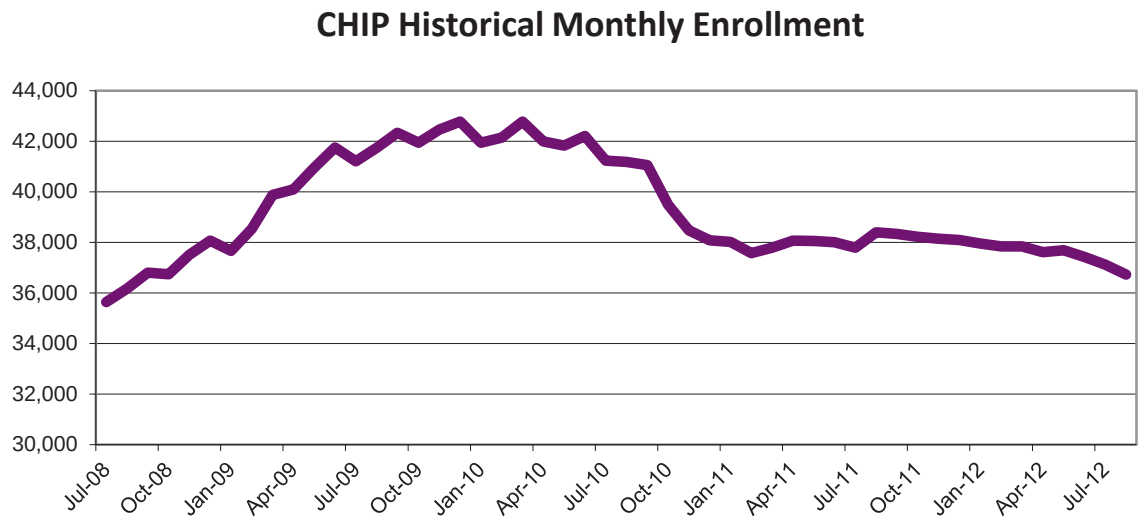


Figure 15

Services

CHIP SERVICES

Medical – CHIP provides a comprehensive insurance which covers the following medical benefits:

- Well-child exams
- Immunizations
- Doctor visits
- Specialist visits
- Medical emergency services
- Ambulance
- Urgent care
- Ambulatory surgical
- Inpatient and outpatient hospital services
- Lab & x-rays
- Prescriptions
- Hearing and vision screening exams
- Mental health services

Dental – CHIP provides the following benefits up to an annual maximum of $1,000:

- Preventive services
- Fillings
- Extractions
- Oral surgery
- Crowns
- Bridges
- Dentures
- Endodontics
- Periodontics
- Orthodontics

UPP SERVICES

In an effort to create private health insurance opportunities for individuals that qualify for CHIP, DOH obtained federal approval to offer families the ability to purchase their employer-sponsored health insurance rather than enroll their children in CHIP. Beginning November 1, 2006, qualified families were eligible to receive a rebate when they purchased health coverage through their work. In addition, qualified families also receive an additional rebate if they purchase dental coverage through their work. If the family does not purchase dental coverage for their children through their work, the children can be enrolled in CHIP dental coverage, which was provided through Premier Access and DentaQuest in SFY 2012. Those rebates are currently up to $120 per child per month for medical coverage and an additional $20 per child per month for dental coverage.

In September 2012, there were 278 children enrolled in Utah's Premium Partnership for Health Insurance (UPP). Of the 278 enrollees, 232 received both the medical and dental subsidy and 46 received the medical subsidy and enrolled in the CHIP dental plan.

In December 2009, UPP was given approval by CMS to help low-income individuals and families pay for their COBRA coverage. Now families either COBRA eligible or already enrolled in COBRA may qualify to receive up to $150 per adult each month and up to $140 per child each month to help subsidize their monthly COBRA premium payment.

As directed by state law, DOH pushed the federal government to approve an amendment that would allow UPP to provide rebates to families that purchase private, non-group coverage. This amendment was originally submitted in September 2008. DOH also included this amendment request in a waiver renewal request submitted in February 2010. In spite of an aggressive three year effort to obtain approval for this amendment, CMS rejected DOH's proposal citing a lack of controls in the insurance industry and concerns that low-income families may be taken advantage of in this process.

On March 24, 2010, President Obama issued an Executive Order that clarified how rules limiting the use of federal funds for abortion services would be applied to the new health insurance exchanges. DOH determined that the Executive Order in conjunction with the intent of state law regarding the use of public funds for abortion created new expectations in regards to the UPP subsidy. An emergency rule, effective April 1, 2010, was filed to prohibit UPP from reimbursing families that were enrolled in plans covering abortion services beyond the circumstances allowed for the use of federal funds (i.e., life of the mother, rape, or incest). In order to be eligible for UPP the insurance plan the family wishes to enroll in must meet the definition of "creditable coverage" as defined in Utah Administrative Code.

UPP Client Story:

Like many uninsured Utah families, Karen and her husband were relieved to learn about UPP. Prior to enrolling in their employer's insurance plan, the family of seven avoided going to the doctor unless it was an emergency. "It has really helped me because I can have insurance and pay the doctors bills that I have to pay ," said Karen.

Appendix A: Glossary

TITLE XIX - MEDICAID	Title XIX of the Social Security Act requires states to establish Medicaid programs to provide medical assistance to low income individuals and families. Within broad federal rules, each state decides eligible coverage groups, eligibility criteria, covered services, payment levels, and administrative and operating procedures.
TITLE XXI – STATE CHILDREN'S HEALTH INSURANCE PROGRAM	The purpose of Title XXI is to provide funding to assist states in providing medical coverage to uninsured, low income children in an effective manner.
AID CATEGORIES	A designation under which a person may be eligible for medical assistance.
ARREARS	The amount of money owed to a state or to a Non-IV-A participant that was not paid when due.
CAPITATION	A reimbursement method where the contractor is paid a fixed amount (premium) per enrollee per month.
CATEGORY OF ASSISTANCE	A group of aid categories consisting of clients with similar Medicaid eligibility. Examples include Aged, Blind and Disabled.
CATEGORY OF SERVICE	A group of services that are provided by a common provider. Examples include Inpatient Hospital, Outpatient Hospital and Physician Services.
CHIP	The Children's Health Insurance Program is a state health insurance plan for children. Depending on income and family size, working Utah families who do not have other health insurance may qualify for CHIP.
CLAWBACK PAYMENTS	Federally required payments to the Medicare program that began in 2006 to cover the pharmacy needs of Medicare clients that were also eligible for Medicaid.
CMS	Centers for Medicare and Medicaid Services is a federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.
DOH	Refers to the Utah Department of Health.
DHS	Refers to the Utah Department of Human Services.
DSH	Disproportionate Share payments made by the Medicaid program to hospitals designated as serving a disproportionate share of low-income or uninsured patients. DSH payments are in addition to regular Medicaid payments for providing care to Medicaid beneficiaries. The maximum amount of federal matching funds available annually to individual states for DSH payments is specified in the federal Medicaid statute.
DWS	Refers to the Utah Department of Workforce Services.
ELIGIBLE	An individual who is qualified to participate in the Utah State Medicaid or CHIP program but may or may not be enrolled.
ENROLLEE	An individual who is qualified to participate in Utah's Medicaid or CHIP program and whose application has been approved but he or she may or may not be receiving services.

FMAP	Federal Medical Assistance Percentage is the percentage the federal government will match for state money spent on Medicaid.
MANAGED HEALTH CARE	A system of health care organizations that contract with Medicaid to provide medical and mental health services to Medicaid clients.
MEDICAID RESTRICTED ACCOUNT	The General Fund Restricted Account created to hold any general funds appropriated to the DOH for the state plan for medical assistance or for the Division of Medicaid and Health Financing that are not expended in the fiscal year for which the general funds are appropriated and which are not designated as nonlapsing. Unused state funds associated with the Medicaid program from DWS and DHS and any penalties imposed or collected under various statutes shall be deposited. See UCA 26-18-402 for more detail.
NURSING CARE FACILITIES ACCOUNT	Proceeds from the assessment imposed by Section UCA 26-35a-104 which are deposited in a restricted account to be used for the purpose of obtaining federal financial participation in the Medicaid program.
PCN	Primary Care Network is a health plan for adults administered by DOH. It covers services administered by a primary care provider. Applications are accepted only during open enrollment periods.
PARTICIPATING PROVIDER	A provider who submitted a bill to Utah's Medicaid program for payment during the fiscal year.
PRESUMPTIVE ELIGIBILITY	Provides limited and temporary coverage for pregnant women whose eligibility is determined by a qualified provider prior to an agency determination of Medicaid eligibility.
RECIPIENTS (CLIENTS)	The unduplicated number of enrollees who had paid claim activity during a specific time period. This count is unduplicated by category of service as well as in total.
SEED	State funds appropriated to agencies outside the Division of Medicaid and Health Financing that are transferred to the Utah Department of Health in order to draw down the federal match for Medicaid activities that occur within those other agencies.
SPENDDOWN MONEY	Clients that have too much income to qualify for Medicaid can spenddown their income if they have qualifying medical expenses that bring their net income to Medicaid levels.
STATE FISCAL YEAR (SFY)	The State Fiscal Year is a 12-month calendar that begins July 1 and ends June 30 of the following calendar year.
TANF	The federal block grant program Temporary Assistance for Needy Families, which succeeds the Aid to Families with Dependent Children program. In Utah, this program is known as the Family Employment Program (FEP).
TPL	Third Party Liability. Individuals or entities who have financial liability for medical costs of Medicaid recipients.
TRENDS	A measure of the rate at which the data is changing. Trends are calculated by the least squares method based on the past twelve months of date up to and including the current month.
UNDUPLICATED COUNT	Recipients who are counted only once regardless of whether they used one or more categories of service or are covered by one or more categories of assistance.

UNITS OF SERVICE	A measure of the medical service rendered to a client. The unit of measure of a service unit will vary with the type of claim. For example, the service unit for an inpatient hospital claim is days of stay, while the service unit for a dental claim is procedures.
WAIVER	The waiving of certain Medicaid statutory requirements which must be approved by CMS (see Appendix B).
WELFARE REFORM	New federal requirements as a result of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996.

Appendix B: Utah Medicaid Waivers

Waiver programs currently in effect in the State of Utah:

WAIVER TYPE 1115

Primary Care Network (PCN)

PCN is a health plan for adults offering services from primary care providers. The federal government requires that more parents be enrolled than adults without children. Since 2002, Waiver Type 1115 has enabled funding for Nontraditional Medicaid (average 21,000 adults annually), PCN (19,000 adults, and Utah's Premium Partnership for Health Insurance (UPP) (over 200 adults and 500 children annually). Funding for adults is through Title XIX (Medicaid). Children are funded through Title XXI (CHIP).

WAIVER TYPE 1915B

(i) **Choice of Health Care Delivery Program & Hemophilia Disease Management Program**
This program grants operating authority to allow Medicaid to require Traditional Medicaid clients living in Davis, Salt Lake, Utah, and Weber counties to select a health plan that provides services in accordance with the program's waiver. In addition, this is the operating authority to allow Medicaid to contract with a Utah licensed pharmacy for the provision of anti-hemolytic factors to Utah's Medicaid clients with hemophilia.

(ii) **Prepaid Mental Health Plan**
This waiver allows Medicaid to mandatorily enroll most Title XIX recipients in 27 counties in this plan. Contracted mental health centers provide services covered under the waiver on an at-risk capitation basis.

WAIVER TYPE 1915C

(i) **Technology Dependent, Medically Fragile**
This program offers the choice of home and community-based alternatives for technology dependent, medically fragile individuals with complex medical conditions, who would otherwise require placement in a Medicaid enrolled nursing facility to obtain needed services (the costs of which would be borne by Medicaid). The waiver operates statewide, and serves a maximum of 120 recipients at any point in time.

This program permits the State to furnish an array of home and community-based services (in addition to Medicaid state plan services) necessary to assist technology dependent individuals with complex medical needs to live at home and avoid institutionalization. Responsibility for the day-to-day administration and operation of this waiver is shared by the Medicaid agency and the Division of Family Health and Prevention (also under the umbrella of the Single State Medicaid Agency). The Medicaid agency provides the State matching funds for this program.

(ii) **Community Supports Waiver**
This program serves over 4,400 individuals with intellectual disabilities in home and community-based setting as an alternative to institutional care in an Intermediate Care Facility for People with Mental Retardation (ICF/MR). The Operating Agency is DHS, Division of Services for People with Disabilities.

This program's primary focus is to provide services to children and adults with intellectual disabilities. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for services provided in an intermediate care facility for people with mental retardation (ICF/MR). The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

(iii) **Aging Waiver**

This program serves nearly 600 individuals over the age of 65 in home and community-based settings as an alternative to institutional care in a nursing facility. The Operating Agency is DHS, Division of Aging and Adult Services.

This program's primary focus is to provide services to elderly individuals in their own homes or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. DHS, Division of Aging and Adult Services, provides for the day-to-day operation and the state funding of this program.

(iv) **Acquired Brain Injury Waiver**

This program serves approximately 100 individuals with acquired brain injuries in home and community-based settings as an alternative to institutional care in a nursing facility. The Operating Agency is DHS, Division of Services for People with Disabilities.

This program's primary focus is to provide services to adults who have sustained acquired brain injuries. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for nursing home care. The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

(v) **Physical Disabilities Waiver**

This program serves approximately 120 individuals with physical disabilities in home and community-based settings as an alternative to institutional care in a nursing facility. The Operating Agency is DHS, Division of Services for People with Disabilities.

This program's primary focus is to provide services to adults who have physical disabilities. Services are provided in an individual's own home or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. DHS, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

(vi) **New Choices Waiver**

This program is able to serve up to 1,400 people who were nursing facility residents or licensed assisted living facility residents immediately prior to enrolling in the waiver. The program provides services to these individuals in home and community-based settings as an alternative to institutional care in a nursing facility. Operation and administration of this waiver is completed by the Department of Health, Division of Medicaid and Health Financing.

The purpose of this waiver is to assist individuals to receive long term care services in a community-based setting rather than in a nursing facility.

APPENDIX C: Comparison of Adult Medicaid Programs

A provider can refuse to see you, if you do not pay your co-pay.

Benefit	Traditional Medicaid (usually 18 years or older)	Non-Traditional Medicaid (usually 19 years or older)	Primary Care Network (PCN) (19 years or older)
Out of Pocket Maximum	**Pharmacy:** $15 per month **Inpatient:** $220 per year **Physician & Outpatient:** $100 per year combined	$500 per calendar year per person	$1,000 per calendar year/ per person (up to $50 enrollment fee not included)
Dental	Not covered	Not covered	10% co-pay (limited benefits)
Emergency Room	$0 co-pay ($6 co-pay for non-emergent use of the ER)	$0 co-pay ($6 co-pay for non-emergent use of the ER)	$30 co-pay (see PCN Member Guide for limitations)
Family Planning	**Office visit:** $0 co-pay **Pharmacy:** $0 co-pay (see current OTC list)	**Office visit:** $0 co-pay **Pharmacy:** $0 co-pay (see current OTC list) *Implants & patches are not covered*	**Office visit:** $5 co-pay **Pharmacy:** $5 co-pay for generic & OTC (see current OTC list) *Implants & sterilization are not covered*
Inpatient Hospital	$220 co-pay yearly for non-emergent stays	$220 co-pay for each non-emergent stay	Not covered
Lab	$0 co-pay	$0 co-pay	5% co-pay of allowed amount if over $50
Medical Equipment & Supplies	$0 co-pay	$0 co-pay	10% co-pay for covered services
Mental Health	$0 co-pay at Prepaid Mental Health Center	$0 co-pay (30 annual inpatient, 30 annual outpatient visits maximum)	Not covered
Occupational & Physical Therapy	$0 co-pay	$3 co-pay (limited 6 visits per year total)	Not covered
Office Visit & Outpatient	$3 co-pay ($0 co-pay for preventive care or immunizations)	$3 co-pay ($0 co-pay for preventive care or immunizations)	**Outpatient:** Not covered **Office visit:** $5 co-pay (pregnancy related services not covered)
Pharmacy	*$3 co-pay per prescription (limited to $15 per month) Limited over-the-counter drug coverage	$3 co-pay per prescription Limited over-the-counter drug coverage	**Generic** - $5 co-pay **Brand Name** - 25% co-pay (limited to 4 prescriptions per month)
Transportation	$0 co-pay	$0 co-pay (limited to emergency transportation)	$0 co-pay (limited to emergency transportation)
Vision	**Optometrist** - $0 co-pay for annual eye exam **Ophthalmologist** - $3 co-pay for annual eye exam *Glasses are not covered*	Annual coverage limited to $30 for a medically necessary eye exam *Glasses are not covered*	$5 co-pay for annual exam *Glasses are not covered*
X-ray	$0 co-pay	$0 co-pay	5% co-pay of allowed amount over $100

- American Indians, pregnant women and children are excluded from co-pays. In addition to Traditional Medicaid benefits, pregnant women and children will receive dental and chiropractic benefits.
- Other insurance or Medicare may affect co-pay and co-insurance.

This chart may change at any time without notice. Updated November 2012.

2012

Utah Annual Report of MEDICAID & CHIP

UTAH DEPARTMENT OF HEALTH
MEDICAID
A Bridge to Wellness for Utah's Vulnerable